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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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ELIGIBILITY

DD waivers services are available to eligible individuals, including children, with a developmental disability (DD) who have been determined to require the level of support provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). These services must be determined to be an appropriate service alternative to exit from, delay or avoid placement in an ICF-IID and necessary to ensure community integration.

Only individuals residing within the physical boundaries of the Commonwealth are eligible to be authorized and have their services reimbursed through the waiver.

While individuals who are inpatients of a hospital, nursing facility, ICF-IID, or inpatient rehabilitation facility may be on the waiting list and may receive limited support coordination, they are not eligible to be authorized to receive waiver services (with the exception of Transition Services) until exiting the institution and being enrolled in the waiver.

In order to be approved for a DD waiver, an individual must meet the following criteria:

- Have a developmental disability;
- Have significant functional limitations in major life activities, as documented on the age appropriate version of the Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) form;
- Meet Medicaid financial eligibility criteria; and
- Indicate willingness to accept waiver services within 30 days of slot assignment.

Diagnostic Eligibility

For the purposes of these waivers, “**intellectual disability**” is defined as follows (according to the Code of Virginia - § 37.2-100. Definitions.

Intellectual disability" means a disability, originating before the age of 18 years, characterized concurrently by (i) significant sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and

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(ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

For the purposes of these waivers, “**developmental disability**” is defined as follows (according to the Code of Virginia):

"Developmental disability" means a severe, chronic disability of an individual that:

- Is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness;
- Is manifested before the individual reaches 22 years of age;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
- Reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in bullets listed directly above if the individual, without services and supports, has a high probability of meeting those criteria later in life.

“Age of Onset” clarification - For some individuals who come to the attention of waiver screeners later in life, school records no longer exist, the individual did not complete their education, or special education services were not even in existence at the time. In order to meet the second component of the definition of developmental disability, it is acceptable for the professional who completes the testing/evaluation to affirm the other required components of the definition also to include a written attestation regarding age of onset. This attestation must indicate that, based on familial report or other evidence (such as that gleaned from past hospitalizations or institutional stays), the developmental disability has existed since the developmental period.

Documentation of the above may include one or more of the following, as may be appropriate for the diagnosis. This documentation must address the above criteria and reflect the individual’s current functioning:

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- Psychological evaluation
- School testing/records
- Part C assessments
- Occupational Therapy/Physical Therapy/Speech and Language Therapy assessments
- Adaptive assessments
- Social history
- Medical records
- Social Security Administration determination.

The diagnosis may originate from a medical doctor, Occupational Therapist, Physical Therapist, Speech and Language Therapist, psychologist, or other professional acting within his scope of practice. An updated evaluation confirming diagnosis may be required if an individual's functioning changes significantly while receiving waiver services.

Functional Eligibility

Functional eligibility for the waiver is determined through the use of the Virginia Intellectual Developmental Disabilities Eligibility Survey (VIDES) appropriate to the individual according to his/her age, completed no more than six months prior to waiver enrollment and annually, prior to the ISP meeting, once waiver services have begun.

The VIDES must be conducted by a qualified Support Coordinator in person (face-to-face) with the individual and, as applicable, another person who knows the individual well. The results of the VIDES must be recorded in the Waiver Management System (WaMS).

If the individual to be screened resides out of state, the VIDES may be completed through the use of remote technology that allows the Support Coordinator to view the individual and converse with him/her and any other person who knows the individual well, as appropriate. The interactive audio/video connection must be of sufficient audio quality and visual clarity so as to be functionally equivalent to a face-to-face encounter, conducted in a confidential manner and any information sharing consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable.

The three versions of the VIDES are as follows:

- VIDES for infants must be used for the evaluation of individuals who are younger than three years of age (DMAS-P235). Two or more of five categories must be met.
- VIDES for children must be used for the evaluation of individuals who are three years of age through 17 years of age (DMAS-P-236). Two or more of seven categories must be met.
- VIDES for adults must be used for the evaluation of individuals who are 18 years of age and older (DMAS-P237). Three or more of eight categories must be met.

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The VIDES may not be completed in its entirety by either the individual's family or service providers.

Financial Eligibility

Once assigned a waiver slot, the individual must be found to be financially eligible for Medicaid services in order to receive DD waiver services. Local departments of social services (LDSS) determine an individual's financial eligibility for Medicaid. Some individuals not otherwise financially eligible for Medicaid may be eligible to receive DD waiver services.

Patient Pay

Some individuals who are approved for Medicaid under eligibility rules unique to waiver recipients may have a patient pay responsibility. Patient pay refers to an individual's obligation to pay towards the cost of long term services and supports if the individual's income exceeds certain thresholds. This means that Virginia reduces its payment for DD waiver services by the amount of the individual's income remaining after all allowable deductions are made for "personal maintenance needs."

Patient pay is determined by the LDSS using the following methodology:

- The allowable income level used for waivers is 300% of the current supplemental security income (SSI) payment standard for one person.
- Under the DD Waivers, the coverage groups authorized under the Social Security Act is considered as if the individual were institutionalized for the purpose of applying institutional deeming rules. All individuals under the waivers must meet the financial and nonfinancial Medicaid eligibility criteria and meet the level-of-care criteria for an ICF/IID. The deeming rules are applied to waiver eligible individuals as if the individuals were residing in an ICF/IID or would require that level of care.
- The Commonwealth will reduce its payment for DD waiver services provided to an individual 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 federal guidelines. DMAS will reduce its payment for DD waiver services by the amount that remains after the following deductions:
 - For individuals to whom § 1924(d) of the Social Security Act applies and for whom the Commonwealth waives the requirement for comparability pursuant to § 1902(a)(10)(B), DMAS will deduct the following in the respective order:

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- The basic maintenance needs for an individual under the DD Waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual will have an additional income allowance. For an individual employed 20 hours or more per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least four hours but less than 20 hours per week, earned income will 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% of the individual's total monthly income, will be added to the maintenance needs allowance. However, in no case will the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.
- For an individual with only a spouse at home, the community spousal income allowance determined in accordance with the Social Security Act.
- For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with the Social Security Act.
- 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.
- 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 will deduct the following in the respective order:
 - The basic maintenance needs for an individual under the DD Waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual will have an additional income allowance. For an individual employed 20 hours or more per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least four but less than 20 hours per week, earned income will 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% of the individual's total monthly income, will be added to the maintenance needs allowance. However, in no case will the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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- For an individual with a dependent child, an additional amount for the maintenance needs of the child, which is equal to the Title XIX medically needy income standard based on the number of dependent children.
- 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.

DMAS will reimburse the providers only for services that are not covered by the patient pay.

The patient pay determination is initiated when an individual's Support Coordinator notifies the LDSS via the DMAS-225 that the individual has been approved for DD Waiver services or the individual receiving DD waiver services experiences a change in circumstances, income, or assets.

The LDSS will determine an individual's patient pay amount obligation into the Medicaid Management Information System (MMIS) or other Medicaid informational system adopted by the administering Medicaid agency at the time action is taken as a result of an application for waiver services, redetermination of eligibility, or reported change in an individual's situation. That amount is transmitted electronically to the Medicaid Enrollment and Claims system.

If an individual receiving DD Waiver services has a patient-pay amount, a provider is designated to collect the patient pay. Providers designated to collect patient pay are responsible for collecting the patient pay amount and reducing the claim for Medicaid payment of DD Waiver services by that amount.

Verification of an individual's patient pay obligation will be available through the web-based Automated Response System (ARS) and telephone-based MediCall system. Responsible providers, as designated by the Support Coordinator, must monitor the ARS/MediCall systems in order to determine the appropriate amount of patient pay to collect. These verification systems allow the provider to access information regarding Medicaid eligibility, claims status, check status, service limits, service authorization, and pharmacy prescriber identification.

The website to enroll for access to this system is <https://rb.gy/76e7sn> The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Information regarding how to access these systems is included in Chapter 1 of each provider manual.

The DMAS-generated Notice of Approval of Pre- Authorized Services serves as the provider's confirmation of individual eligibility and authorization to bill for waiver services. Only the cost of

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medically necessary, individual-specific, customized, non-covered items or services may be deducted from patient pay by the eligibility worker.

The assigned provider should include the patient pay on the claim. Providers must submit claims for all services, even if the provider does not expect reimbursement for a claim due to patient pay. MMIS is only able to track patient pay when a claim is submitted. Providers are responsible for collecting only the amount of patient pay that is deducted from their claim.

PATIENT PAY CONSUMER DIRECTED SERVICES

The only exception to application of patient pay rules stated above is for those choosing to self-direct their consumer-directed services.

Agency providers need to document how the actual patient pay amount was obtained. The F/EA is responsible for ensuring the patient pay amount is withheld from CD reimbursement.

MEDICAID LTC COMMUNICATION DOCUMENT (DMAS-225)

It is the responsibility of the Support Coordinator to complete the DMAS-225 form. The form is sent to the LDSS for review by an eligibility worker and determination on patient pay responsibility. The DMAS-225 is then sent back to the Support Coordinator. The Support Coordinator will review the DMAS-225 and, for individuals who have a patient pay obligation, identify the provider with the highest potential billing amount and inform the provider in writing that they must collect the patient pay.

The DMAS-225 will be used to advise the LDSS staff which provider is responsible for collecting the individual's patient pay obligation. The Support Coordinator, should complete the Provider NPI# (or API) data field on the DMAS-225. The DMAS-225, when completed by the LDSS, will then be used to inform the Support Coordinator of the individual's eligibility status.

Once a responsible provider is identified, the Support Coordinator forwards a computer generated confirmation of level of care eligibility and the DMAS-225 (with the top portion completed) to the LDSS indicating that the individual has met the level of care requirements and providers have been selected.

Following verification that the individual has been screened and approved to receive DD Waiver services, the LDSS eligibility worker will determine the individual's Medicaid eligibility, complete the LDSS portion of the DMAS-225 and return it to the Support Coordinator with the bottom section completed, showing confirmation of the individual's Medicaid identification number and the date on which the individual's Medicaid eligibility was effective.

The Support Coordinator must maintain a copy of the DSS-completed DMAS-225 in the individual's support coordination file.

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The Support Coordinator may monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. DSS is responsible for notifying the Support Coordinator if the individual no longer meets eligibility requirements and for updating the Support Coordinator of changes to an individual's eligibility.

The DMAS-225 is also used by the Support Coordinator and the LDSS to exchange information that may affect the eligibility status of an individual. The Support Coordinator must complete an updated DMAS-225 and forward it to the LDSS eligibility worker whenever an individual experiences any of the following:

- A change in address;
- A change in provider of support coordination services;
- An increase or decrease in monthly income;
- A change in collector of patient pay;
- Discharge from all DD Waiver services;
- An interruption in all DD Waiver services for more than 30 consecutive days; and
- Death.

The Support Coordinator must update the DMAS-225 and submit it to the LDSS within 5 business days following any of these changes. The exact change in circumstances and reason for the change must be clearly noted on the DMAS-225.

DD WAIVERS ENROLLMENT AND WAITING LIST

The individual who has been found to be eligible for the DD waivers will be given, by the Support Coordinator, his choice of either institutional placement or receipt of home and community-based waiver services. The "Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services" (DMAS 459-C) form is used by the Support Coordinator to give eligible individuals their choice of either institutional placement or receipt of home and community-based waiver services. If the individual selects home and community-based waiver services, electronic confirmation by DBHDS is received that a slot is available, and an Individual Support Plan that ensures the individual's safety can be developed, then the Support Coordinator may enroll the individual in the waiver.

When an individual has been found eligible for and desires services through the DD waivers, but there is not a slot available, the individual may be added to the DD waivers waiting list by the Support Coordinator. To be placed on the waiting list for the DD Waivers (referred to as the waiting list) both diagnostic eligibility and functional eligibility (determined through completion of the VIDES) must be met. The following is also needed:

- Documentation of the date of need,
- The types of services sought, and

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- The “Documentation of Recipient Choice between Institutional Care or Home, and Community-Based Services” (DMAS 459-C) form.

Within 10 business days of placement on the waiting list, the Support Coordinator must notify the individual in writing that:

- He or she has been placed on the waiting list,
- His or her priority level status, and
- Offer appeal rights (see the “Individual’s Right to Appeal and Fair Hearing” section of Chapter VI for details).

Placement on the waiting list occurs in WaMS.

While an individual must not be simultaneously enrolled in more than one waiver, an individual who has a diagnosis of DD may be on the waiting list for the DD Waivers while simultaneously being enrolled in the Commonwealth Coordinated Care Plus Waiver (CCC+ waiver) if the individual meets applicable criteria for either. Individuals who reside in NFs or other institutions who qualify for the DD Waivers may also be on the waiting list.

Individuals who accompany parents or guardians deployed overseas for active duty U.S. military or Foreign Service assignment but retain Virginia residency may, if they so choose, remain on the statewide DD waivers waiting list and be considered for DD waivers slot assignment when they are within three months of returning to Virginia.

There must be annual documentation of contact with each individual on the waiting list to provide the choice between waiver and institutional placement through completion of the Attestation Documentation of Individual Choice for Home and Community-Based Services” (DMAS 459-C) form and updating of the types of services sought/needed. During the month in which the individual was added to the waiting list DBHDS sends, via postal mail to the adult individual or identified representative, the two forms mentioned above. These forms may also be completed online via the WaMS Waitlist Portal. If the forms are not completed in the WaMS portal or received back within 30 days, DBHDS will attempt a second mailing of the forms, plus the Notice of Action letter informing the individual that he/she will be removed from the waiting list if the second set of forms are not completed in the WaMS portal or received within 60 days. At the end of the 60 days, if no forms are received or appeal filed, the individual’s name will be removed from the waiting list. Quarterly, CSBs will receive completed Choice forms for individuals on their portion of the waiting list for inclusion in their files and a report of the names of individuals whose names have been removed from the waiting list.

Waiting List Priority Status and Criteria

In order to ensure waiver services are provided to those with the most urgent need, the Support Coordinator/case manager will identify, after discussion with the individual and family/caregiver,

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as appropriate, the priority status that best reflects the situation of the individual seeking waiver services. The waiting list includes Priority One, Priority Two and Priority Three categories. The individual will be assigned the priority level that best describes his/her need for waiver services by meeting at least one criterion in the category. This decision will be documented using the DD Waivers' Priority Criteria Checklist form. Also documented on this form is confirmation that the individual, the individual's spouse, or the parent of an individual who is a minor child would accept DD waiver services within 30 days of slot assignment.

Only those individuals who meet Priority One criteria and are willing to accept services within 30 days of slot assignment are eligible to be reviewed for a CL or FIS slot, until such time as all individuals in the Priority One group have received slots.

Priority One:

This designation will be given to individuals who will require a waiver service *within one year* and are determined to meet at least one of the following criteria:

- 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 that currently significantly limits the ability of the primary caregiver to care for the individual; or there are no other unpaid caregivers available to provide supports.
- 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:
 - The individual's behavior, presenting a risk to himself or others, cannot be effectively managed even with Support Coordinator-arranged generic or specialized supports; or
 - There are physical care needs or medical needs that cannot be managed even with Support Coordinator-arranged generic or specialized supports
- The individual lives in an institutional setting and has a viable discharge plan; OR
- The individual is a young adult who is no longer eligible for IDEA services and has expressed a desire to live independently. After individuals attain 27 years of age, this criterion will no longer apply.

Priority Two:

This designation will be given to individuals who will need a waiver service in *one to five years* and are determined to meet at least one of the following criteria:

- The health and safety of the individual is likely to be in future jeopardy due to:

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- The unpaid primary caregiver having a declining chronic or long-term physical or psychiatric condition that currently significantly limits his/her ability to care for the individual,
- There are currently no other unpaid caregivers available to provide supports, or
- The individual's skills are declining as a result of lack of supports.
- The individual is at risk of losing employment supports,
- The individual is at risk of losing current housing due to a lack of adequate supports and services, or
- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

Priority Three:

This designation will be given to individuals who will need a waiver slot in *five years or longer* as long as the current supports and services remain and have been determined to meet at least one of the following criteria:

- The individual is receiving a service through another funding source that meets current needs,
- The individual is not currently receiving a service but is likely to need a service in five or more years, or
- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

Individuals and family/caregivers, as appropriate, have the right to appeal the determination of the individual's priority level.

If an individual determines at any time that he or she no longer wishes to be on the waiting list, the individual may contact his Support Coordinator and request removal from the waiting list. The Support Coordinator will notify DBHDS and the individual's name will be removed from the waiting list. The Notice of Action form generated by the Virginia Waiver Management System is generated and sent by the Support Coordinator to the individual informing the individual of their right to appeal this decision.

A review of the individual's status and a new Priority Criteria Checklist will be completed by the Support Coordinator when the needs of the individual change, but ideally no less than once every

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three years. Any changes to an individual's priority status or removal from the waiting list due to change in status are communicated to DBHDS via WaMS. When an individual's priority level decreases or change in waiting list status is made, the individual and family member/caregiver, as appropriate, must be notified in writing of his or her appeal rights. Changes in status that require notification of appeal rights are indicated on the Notice of Action form.

Critical Needs Summary Step 1 Review

All individuals meeting the Priority One criteria must have a Critical Needs Summary – Step 1 Review form completed by their Support Coordinator in WaMS as soon as possible after the determination is made that they meet the criteria. This form should be based on documented information in the individual's record (family report, intake summary, reports by professionals, etc., as appropriate). The Critical Needs Summary form will generate a Critical Needs Summary score that is maintained in WaMS.

The Critical Needs Summary form for each individual on the waiting list must be reviewed and updated annually after the first CNS, and whenever the individual's "critical needs" change.

DD WAIVERS SLOT MANAGEMENT

Slot Allocation

When the General Assembly has approved less than 40 new slots for a given waiver, the available slots will be allocated by DBHDS to regions or sub-regions of the state for distribution to the individuals in that region or sub-region who are determined to have the most urgent needs. If there are BI slots to be allocated, the BI slots will be allocated by region.

When at least 40 new Community Living or Family and Individual Supports waiver slots are funded by the General Assembly, one slot will be allocated by DBHDS to each CSB. Additional slots up to the total number of available slots for a given waiver will be allocated to CSBs for individuals living within that CSB's catchment area based upon a formula combining the following objective factors and criteria:

- The region's population,
- The percentage of Medicaid eligible individuals in the catchment area, and
- Each CSB's percentage of individuals on the "Priority One" portion of the statewide waiting list.

Individuals are enrolled into a DD Waiver when a slot becomes available to their local CSB or region. This may occur through attrition or through the allocation of new slots to the CSB or region.

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Slot Assignment – Community Living and Family and Individual Supports Waivers

When it is anticipated that a vacant slot or slots will become available for assignment, the Support Coordinators for the individuals with the highest Critical Needs Summary scores will prepare written summaries of the individuals' needs on the "Slot Assignment Review" form in WaMS. Completed forms will be distributed to Waiver Slot Assignment Committee (WSAC) members in advance of the meeting to permit sufficient time for a thorough reading. This may include individuals new to the system who have not yet been placed on the Statewide Waiting List.

A Waiver Slot Assignment Committee (WSAC) is the impartial body of trained volunteers established for each locality or region with responsibility for recommending to DBHDS individuals eligible for a waiver slot according to their urgency of need at the time a slot becomes available. All WSACs must be composed of community members who are not employees of a CSB or a private provider of either support coordination or waiver services and are knowledgeable of and have experience in the developmental disabilities service system. When a slot is available, the CSB will contact the WSAC facilitator, who will coordinate with DBHDS staff to call a meeting of the committee as soon as possible.

The determination of the number of individuals to be reviewed by the WSAC follows the following procedures:

- If the number of available slots is 5 or less, the 10 top-ranking Critical Needs Summary (CNS)-Step 1 individuals will be considered for review;
- If there is more than one individual ranked at number 10, all equally scoring individuals at the cut-off point will be considered for review. For example, if three individuals in the "number 10 spot" have the same score all three will be reviewed, making the total to be reviewed 12 instead of 10;
- If a CSB has more than 5 slots available, the number of top-ranking individuals reviewed will be double the number of available slots. For example, if 7 slots are available, the number of top ranking CNS-Step 1 individuals moving to WSAC review will be 14. In this example, if there is more than one individual ranked at number 14, all equally scoring individuals at the cut-off point will be included for consideration in the Step 2 review.

The Support Coordinator, Support Coordinator Supervisor, or designee will be available to provide information to the WSAC about the person being considered, but may not be a voting member of the committee. Slots are assigned by DBHDS based on the recommendations from WSACs on who should be served first due to urgency of need at the time a slot becomes available.

WSAC members will discuss their impressions based on the information contained in the Slot Assignment Review form. Without knowledge of the type of slots that are available, committee members will rank those in the review pool for urgency based on their need for services, from

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highest to lowest. Using the “Slot Assignment Scoring Summary-Step 2 Review” form, each committee member will assign a numeric score in each of five categories for each individual. These scores will be totaled, thereby arriving at a total score for the committee member. All WSAC members’ scores will be totaled and divided by the number of WSAC members, resulting in a final, decimal-based score. The WSAC will recommend individual(s) with the highest score(s) to DBHDS to receive the available slot(s).

Should there be a tie, WSAC members will re-review and discuss the Support Coordinators’ summaries for those individuals and rescore until one individual emerges with a higher score.

To assure statewide consistency, DBHDS staff will participate in each WSAC meeting as an observer and monitor of the slot assignment process. Following the WSAC meeting, DBHDS staff will pair WSAC recommended individuals with the type of waiver slot that will best meet each individual’s needs (e.g., individuals with documented needs for a residential service only available in the CL waiver, such as group home or sponsored residential, will be assigned a CL slot, while individuals seeking supports in the family or individual’s own home will be assigned a FIS slot). DBHDS staff will maintain documentation of the names of individuals reviewed for the slot(s), their respective Step 2 scores from the WSAC meeting, and the name of the individuals who received the available slot(s).

If there are no individuals on the waiting list at a given CSB who required group home or sponsored residential services, vacant CL waiver slots may be held for 90 days in case an individual presents who does need those services. If no one presents, a regional WSAC will be held to assign the vacant CL waiver slot(s).

Following the WSAC meeting, DBHDS staff will assign an individual receiving a slot “projected enrollment” status in WaMS. The Support Coordinator is notified that a slot is available when the Regional Supports Specialist (RSS) moves the individual to projected enrollment status in WaMS. The Support Coordinator must notify the individual and family/caregiver of slot availability and available services within the offered waiver within 7 calendar days of the waiver slot assignment date. This contact must be documented in the individual's record.

The individual or family caregiver, as applicable, will confirm acceptance or declination of the slot within 15 calendar days of notification of slot availability. If the individual or family caregiver, as applicable, has not relayed their decision to the SC within 7 calendar days, the SC shall make and document a second contact. If no decision is forthcoming after 15 calendar days, the SC shall notify DBHDS staff who will remove the individual from projected enrollment status, return him to the waiting list, and take steps to assign the slot to the next highest scoring individual from the review pool.

After the individual has accepted the waiver slot offered by the CSB, the Support Coordinator will provide a print screen of the projected slot enrollment page from WaMS, along with the DMAS-225 (Medicaid Long-Term Care Communication Form) to the LDSS office so that financial

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eligibility for Medicaid and the waiver can be confirmed and any patient pay responsibilities can be determined. After the Support Coordinator has received written notification of Medicaid eligibility from the local department of social services, the Support Coordinator will inform the individual, submit information to DMAS or its designee to enroll the individual in the waiver, and develop the person-centered individual support plan (ISP). A Confirmation of Slot letter will be available in WaMS and should be provided to the individual and his/her caregiver by the Support Coordinator.

In the event that a CSB has a vacant slot but does not have an individual who meets the Priority One criteria, the slot may be held by the CSB for 90 days from the date it is identified as vacant in case someone in that area is identified as meeting Priority One criteria. If no one meeting the Priority One criteria is identified within 90 days, the slot will be made available for allocation to another CSB in the region through a regional WSAC as described below for the BI slot assignment process. If no one meeting in Priority One criteria has been identified within that region, DBHDS will, within 30 days, reallocate the slot to another region where there is unmet Priority One need.

Slot Assignment - Building Independence Waiver

Each of five regional WSACs, composed of one representative from each existing WSAC within the region, will make assignment recommendations for BI waiver slots. If the number of individuals interested in a BI waiver slot with Priority One status for all CSBs in a region is less than the number of available slots, those individuals are assigned a slot without a regional WSAC session occurring. A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for Priority Two and then Priority Three.

When a waiver slot becomes available through attrition, DBHDS will work with the region to determine if there is an individual appropriate for the slot in the region. If not, DBHDS will reassign the slot to a region with individuals who have requested access to a more integrated, independent living arrangement that can be supported through the provision of a minimal level of supports (i.e., through the BI waiver).

Facility Slots

DBHDS may maintain a separate pool of waiver slots for individuals who choose discharge from state-operated facilities and other institutional settings. The Division of Developmental Services (DDS) at DBHDS will track individuals discharged from these settings into waiver slots.

If an individual is readmitted to an institution within 12 months of discharge, and the admission is a long-term admission, the waiver slot will revert to the statewide pool for facility discharges. If the discharged individual resides in the community for 12 consecutive months following discharge, the waiver slot will remain with the CSB providing support coordination services during the 12th month of community residence.

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Emergency Slots

If there are no available slots in the DD waivers and an eligible individual, either on the waiting list or newly known to the CSB, is encountering an emergency situation which may be remedied by a DD waiver slot, the Support Coordinator may apply to DBHDS for consideration for an emergency slot through submission of the “Complex Case Consult for Emergency Access to Waiver Services” form to DBHDS after careful exploration of all other alternatives for the individual by the CSB, Regional Support Team, as appropriate, and DBHDS staff.

Individuals must meet at least one of the emergency criteria below to be eligible for immediate access to waiver services without consideration to the length of time they have been waiting to access services.

- Child protective services has substantiated abuse/neglect against the primary caregiver and has removed the individual from the home, or
- For adults where (i) adult protective services has found that the individual needs and accepts protective services or (ii) 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,
- 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.

The information will be reviewed by the Complex Case Consultation Team (C3T) within 2 business days. DBHDS will consider the individual's circumstances and determine if he meets at least one of the emergency access criteria. Should the C3T affirm that all community options have been considered and explored, an emergency slot will be assigned to the individual, subject to available funding and a finding of eligibility, by the end of the 2nd business day after receipt of the complete request.

If the C3T identifies other alternatives, these will be recommended to include a referral to the Regional Support Team as appropriate.

Emergency slots may be assigned by DBHDS to individuals found to meet emergency criteria for whom no other resources can be identified until the total number of available emergency slots statewide reaches 10% of the emergency slots funded for a given fiscal year, or a minimum of three slots. At that point, the next nonemergency waiver slot that becomes available at the CSB in receipt of an emergency slot must be reassigned to the emergency slot pool in order to ensure the availability of emergency slots for future emergencies within the Commonwealth's fiscal year.

Individuals not previously identified but newly known as needing supports resulting from an emergent situation are also eligible for an emergency slot.

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Reserve Slots

Reserve slots may be used to transition an individual from the DD waiver in which he is presently enrolled into another of the DD waivers. To be considered for a reserve slot there must be a documented change in the individual's assessed support needs that requires a move to another waiver in order to access a needed service(s). Consideration will also be given to whether the individual has attempted to fully utilize the services available in the present waiver.

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

The Support Coordinator will document in writing the change in an individual's assessed needs, which requires a service (or services) that is not available in the DD waiver in which the individual is presently enrolled. The Support Coordinator will submit to DBHDS a "Request for a Reserve Slot" form when an individual meets the above criteria within three business days of knowledge of need.

The assignment of reserve slots will 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. Within three business days of adding an individual's name to the reserve slot list, DBHDS will advise the individual in writing that his name is on the reserve slot list and inform him of his chronological placement on the list. Within three business days of receiving a request from an individual for a status update regarding his placement on the list, DBHDS will advise the individual of his current chronological list number.

When a slot is vacated in one of the DD Waivers (e.g., due to the death of an individual), the slot must be assigned to the next individual in that CSB's chronological queue for a reserve slot in that waiver. When an individual transitions to a new DD waiver using a reserve slot, the waiver slot vacated by that individual will be offered to the next individual in that CSB's chronological queue for a reserve slot in that waiver. If the individual chooses to accept the slot, DBHDS will assign. If there is not an individual in that CSB's chronological queue for a reserve slot in that waiver, the vacated slot will be assigned to an individual on the statewide waiting list who resides in the CSB's catchment area by DBHDS after review and recommendations from the local WSAC.

When a reserve slot becomes available and an individual is identified from the chronological list to access the slot, the Support Coordinator will assure to DBHDS that the service that warranted the transfer to the new waiver (e.g., group home residential) is (i) identified and (ii) a targeted date of service initiation is in place prior to the reserve slot assignment to the new waiver.

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DEVELOPING THE INDIVIDUAL SUPPORT PLAN (ISP)

After the Support Coordinator has received written notification of Medicaid eligibility from the local department of social services, the Support Coordinator will inform the individual, submit information in WaMS to enroll the individual in the waiver, and develop the person-centered individual support plan (ISP).

The Support Coordinator will meet with the individual projected to receive waiver services and the individual's family/caregiver, as appropriate, within 30 calendar days of waiver assignment date to:

- Discuss the individual's assessed needs, existing supports, and preferences;
- Obtain a medical examination, which was completed no earlier than 12 months prior to the initiation of waiver services;
- Update the VIDES as needed so that it is dated no more than six months prior to the start of waiver services;
- Begin to develop the personal profile; and
- Discuss that a Supports Intensity Scale® (SIS) or other developmentally appropriate assessment (for individuals under the age of five years) will need to be scheduled.

Prior to or at the meeting to discuss the individual's assessed needs, the Support Coordinator will provide the individual with a choice of services identified as needed and available in the assigned waiver, alternative settings, and providers. The individual's choices will be documented on the Virginia Informed Choice form (DMAS-460/459A). Once the providers are chosen, the Support Coordinator will schedule a planning meeting with the members of the support team to develop the unique person-centered ISP based on the individual's assessed needs, preferences, and the individual's family/caregiver preferences, as appropriate. The ISP sets out the supports and actions to be taken during the year by each provider, as detailed in each provider's Plan for Supports to achieve desired outcomes, goals, and dreams.

Persons invited by the individual to participate in the person-centered planning meeting may include the individual's family members, planning partner, service providers, and others as desired by the individual. The Support Coordinator must also participate. During the person-centered planning meeting, the services to be rendered to the individual, 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. At a minimum, the individual enrolled in the waiver, or the family/caregiver as appropriate, and Support Coordinator must sign and date the ISP. All Plans for Support, including the Support Coordination PFS, must be signed by the individual, or the family/caregiver, as appropriate. If the signature of the individual receiving services or the family/caregiver, as

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appropriate, cannot be obtained, the provider must document attempts to obtain the necessary signature and the barrier to obtaining it.

Each service provider must submit a copy of his plan for supports to the Support Coordinator. The plan for supports from each service provider will be incorporated into the ISP.

The Support Coordinator will review and ensure all plans 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 for service authorization.

The ISP must contain the following components:

- Part I: Personal Profile;
- Part II: Essential Information;
- Part III: Shared Planning;
- Part IV: Agreements; and
- Part V: Plans for Support.

During the person-centered planning meeting, the services to be rendered to the individual, the frequency of services, the type of provider, and a description of the services to be offered are identified and included in the ISP. The Support Coordinator must complete a risk assessment as part of the planning process. The risk assessment is an assessment used to determine areas of high risk of danger to the individual or others based on the individual's serious medical or behavioral factors. The ISP must then contain the steps and supports needed to mitigate any identified risks.

At a minimum, the individual enrolled in the waiver, the family/caregiver, as appropriate, and Support Coordinator will sign and date the ISP. The Support Coordinator determines the effective date of the ISP. Any services that are added after the initial date of the ISP will be required to be reauthorized upon the ISP's annual date, if not before. Support Coordinators will provide individuals and the family/caregiver, as appropriate, with a copy of the individual's ISP.

The individual, family/caregiver, or Support Coordinator will contact chosen providers so that services can be initiated within 30 calendar days of receipt of written confirmation of waiver enrollment.

DMAS will not reimburse providers for services in ISPs that duplicate payments made to public agencies or private entities under other program authorities for this same purpose, nor reimburse for services that are duplicative of each other. DMAS will only reimburse for services as set out in the individual's ISP. Any payments determined to have been made contrary to these limitations will be recovered by either DMAS or its designee.

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INDIVIDUAL PLANNING CALENDAR (IPC)

Also during the person-centered planning meeting, the Support Coordinator will engage the individual and family/caregiver, as appropriate, in a conversation about how paid services and natural supports are arranged during the week currently and how the individual would like to see those arranged in the future in order to achieve the life he/she wants. This will be recorded on the Individual Planning Calendar (IPC). The IPC is made up of two parts:

- A **current calendar**, which shows how the individual generally spends his/her week right now; and
- An **aspiration calendar**, which shows how the individual might want to spend his/her week in the future, such as spending more time with family and friends, working in the community, living in his/her own apartment, or other goals.

These tools are located in WaMS.

The IPC tools and process are designed to assist the individual and Support Coordinator in charting a path that moves the individual closer to his/her important goals as reflected in the aspiration calendar by examining the person's current calendar and planning together. The use of the IPC is also related to supports packages, which are a set of assumptions regarding the types and amounts of supports that an individual needs to be adequately supported in the community.

It is a model that reflects reasonable services levels based on common expectations for persons who share similar characteristics. Supports packages and the IPC process are designed to ensure that the individual receives enough support based on what he or she needs.

The IPC is completed by the Support Coordinator once a year at the annual ISP meeting.

PLANS FOR SUPPORTS

Each waiver service provider, in conjunction with the individual, the individual's family/caregiver, as appropriate, and the Support Coordinator, will develop a Plan for Supports for that particular service. The Plan for Supports is that provider's plan for supporting the individual enrolled in the waiver in achieving his or her desired outcomes and facilitating his or her health and safety. The provider Plan for Supports is one component of the individual support plan.

At a minimum, the Plan for Supports must contain:

- The individual's desired outcomes that describe what is important to and for the individual in observable terms;
- Support activities and support instructions that are inclusive of skill-building if required by the service provided and that are designed to assist in achieving the individual's desired outcomes;

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- The services to be rendered and the schedule for these services so as 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; and
- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations (12VAC35-115) and the requirements of the HCBS settings regulations (42 CFR 441.301).

Each provider submits a copy of his Plan for Supports to the Support Coordinator so that it may be incorporated into the ISP. Providers are responsible for updating the Plan for Supports when an individual's needs change significantly enough so that the existing Plan for Supports no longer reflect the individual's needs and the supports required to meet those needs (e.g., the individual's medical condition deteriorates necessitating increased supports, new risk factors have been identified necessitating the addition of risk management plans/procedures, etc.).

SERVICE AUTHORIZATION

The Support Coordinator is responsible for reviewing and ensuring that the provider-specific Plan for Supports includes allowable activities for the service, reflects the needs and desires of the individual and is in agreement with the discussion at the ISP meeting before electronically submitting the Plan for Supports in WaMS, along with the results of the comprehensive assessment (i.e., relevant social, psychological, and medical information that are used as basis for the development of the ISP), other required ISP elements, and a recommendation for the final determination of the need for ICF/IID level of care to DBHDS for service authorization. All DD waiver services must be authorized before the provider may bill Medicaid.

Waiver services will be approved and authorized by DBHDS only if:

- The individual is Medicaid eligible as determined by the local department of social services,
- The individual has a diagnosis of developmental disability and would, in the absence of waiver services, require the level of care provided in an ICF/IID,
- The individual's ISP can be safely rendered in the community, and
- The contents of providers' plans for supports are consistent with the ISP requirements, limitations, units, documentation requirements of each service, and the individual's documented needs.

DD waiver services may not be authorized or reimbursed by DMAS for an individual who:

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- Has his permanent residence outside of the physical boundaries of the Commonwealth, or
- Is an inpatient of a hospital, nursing facility, ICF/IID, or inpatient rehabilitation facility.

The Support Coordinator may recommend waiver services that would promote the individual's exiting from an institutional placement. However, with the exception of Transition Services, waiver services may only be provided when the individual has exited the institution and has been enrolled in the waiver.

DMAS will not reimburse providers for the costs of room and board, education, services covered by other payers, or expenses associated with social or recreational activities.

It is the responsibility of the provider to submit service authorization requests to the Support Coordinator for review, approval, and submission to DBHDS via the Waiver Management System (WaMS) to begin services, to modify the amount or type of services, or to end services. The service authorization request must clearly describe the reason for the action. All requests will be reviewed under the health and safety standard. This standard means that an individual needs the service, based on appropriate assessment criteria and a written Plan for Supports, and that services can safely be provided in the community. A justification describing the individual's need for the service and required documentation for the service will be submitted along with the service authorization request. DBHDS is responsible for assuring that the documentation received supports the request. Final recommendation for authorization of DD waiver services is the responsibility of DBHDS. DMAS has the final authority regarding all service authorizations.

The authorized start date of services will not be prior to the date of receipt by DBHDS of a correct, complete authorization request for an eligible individual except for crisis services. To assure the provider that the individual is eligible and that services are authorized as requested, it is recommended that the required documents be submitted at least 30 working days prior to the requested start of services. Requests for EPSDT Private Duty Nursing services for individuals on the DD waivers should be submitted at least 10 days, but no more than 30 days prior to the requested service start or renewal date. All authorization requests will be acted upon (i.e., review of the documentation to determine individual eligibility and the need for and appropriateness of the service being requested, followed by approval, denial, rejection, or pend for additional information) within 10 working days following receipt by DBHDS. (See definition for Approval, denial, rejection or pend in Appendix A of this manual).

When services are approved by DBHDS, the provider and Support Coordinator will be notified via WaMS. At this point, the individual's waiver status becomes "active." For all services a DMAS-generated Notice of Approval of Pre-Authorized Services will be sent to the individual and the specified service provider notifying them of the action taken by DBHDS and the approved hours/units and authorized start date of services. Only waiver services authorized in the Individual

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Support Plan by DBHDS according to DMAS policies and commencing on or after the start date on the Notice of Approval of Pre-Authorized Services will be reimbursed by DMAS.

If the requested services are denied, the provider and Support Coordinator will be notified by DBHDS via WaMS and a DMAS notification letter will be sent to the individual and provider notifying them of the reason for the denial and explaining the individual's appeal rights. Any requests for services that are denied may be resubmitted at a later date if additional justification is obtained.

If DBHDS pends approval of services, notification will be sent to the provider and Support Coordinator explaining the reason for this action and any additional information or action that is required of the provider or Support Coordinator. The Support Coordinator is responsible for submitting the requested information to DBHDS within 30 calendar days. No more than two pends per service authorization request will be permitted. If criteria is not met after receipt of information following the second pend, the request will be rejected or denied. There are no appeal rights with rejected requests and the provider must resubmit the request with a new start date in order to obtain service authorization.

Pending Medicaid Eligibility

DBHDS will notify the provider and Support Coordinator via WaMS if a service authorization request cannot be processed due to a pending Medicaid number. Once the Medicaid number has been issued by the LDSS, the Support Coordinator must save the Medicaid number in the "overview" section of "Person's Information" in WaMS, mark the Medicaid number as "current" by checking the box, and resubmit the request to complete the authorization process. Providers cannot be paid until the Medicaid number has been given to DBHDS.

60-Day Assessment Service Authorization Requests

A 60-day assessment service authorization request may be submitted for group home residential, sponsored residential, supported living residential, in-home supports, independent living supports, agency-directed personal assistance, individual supported employment, group supported employment, group day, community engagement or community coaching. The 60-day assessment service authorization request is authorized only for the assessment period. To continue services after the 60 day assessment, an annual Plan for Supports, developed with the involvement of the individual, must be forwarded by the provider to the Support Coordinator for review and approval. The Support Coordinator must submit the request to DBHDS review prior to the end of the 60 days.

Modifications to Services

To change the amount or type of service previously authorized, a revised Plan for Supports and schedule must be developed with the individual and approved by the Support Coordinator. The

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provider must submit a new service authorization request for review and approval by the Support Coordinator and final authorization by DBHDS.

Multiple Providers

If the individual will be receiving the same service from more than one provider, the Support Coordinator should clearly describe the circumstances to DBHDS in the service authorization request. If changes occur during the Individual Support Plan year, the circumstances should be clearly described on the service authorization request. The second provider will submit a claim with **77 modifier** (Concurrent Care). The modifier alerts DMAS to allow two providers to be paid for the same procedure code on or within the same or overlapping time periods.

Changing Providers

To change a provider for an approved service, the Support Coordinator must submit to DBHDS a service authorization request to terminate the services of the existing provider and a service authorization request to begin services with the new provider.

Ending Services

When services from a waiver provider cease, the service authorization in WaMS should be ended with the last date of service delivery, and the detailed reason for terminating the service should be provided. When all DD waiver services end, this constitutes either an interruption or a discharge from the DD waiver. The Support Coordinator should go to the WaMS “Enrollment” and change the status from active/hold to terminated, pending appeal rights. When the appeal timeframe is completed the Support Coordinator will complete a final release of the waiver slot in WaMS. If the individual is deceased, the waiver slot will automatically be released.

Provider Discontinuation of Services

If, at any time, a provider determines that 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 and DBHDS must be notified by the provider prior to discontinuing services. In a nonemergency situation, when a provider determines that his provision of supports to an individual enrolled in the waiver will be discontinued, the provider must give the individual and the individual's family/caregiver, as appropriate, and Support Coordinator written notification of the provider's intent to discontinue services. The notification letter must provide the reasons for the planned discontinuation and the effective date the provider will be discontinuing services. The effective date of the service discontinuation must be at least 10 business days after the date of the notification letter. The individual enrolled in the waiver may seek services from another enrolled provider. When an individual is transitioning to a different provider, the former provider that served the individual must, at the request of the new provider, provide all medical records and documentation of services to the new provider (consistent with confidentiality requirements,

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including the Health Insurance Portability and Accountability Act and the DBHDS Human Rights regulations) to ensure high quality continuity of care and service provision.

In emergency situations, the above mentioned 10-business-day prior written notification period will 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 and DMAS are to be notified immediately of the emergency discontinuation of services by the Support Coordinator and the provider when the individual's health, safety, or welfare may be in danger.

In both emergency and nonemergency situations requiring discontinuation of services, providers of group home residential services, supported living residential services, and sponsored residential services must comply with the terms set forth in an individual's home and community-based settings residency or lease agreement as described in 42 CFR 441.301.

Delay in Initial Service Initiation/Requests to Retain Slots

If the services are not initiated by the provider within 30 calendar days of the Support Coordinator moving the individual to active enrollment status in WaMS or confirmation of Medicaid eligibility, whichever comes first, the Support Coordinator must notify the local department of social services so that reevaluation of the individual's financial eligibility can be made.

When an individual is referred back to a local department of social services for a redetermination of eligibility and the individual wants to retain the designated slot, the Support Coordinator must, at the same time as submission of notification to the local department of social services, submit a Request to Retain Slot to DBHDS through WaMS requesting retention of the designated slot pending the initiation of services. A copy of the request must be provided to the individual and the individual's family/caregiver, as appropriate.

DBHDS may approve the slot-retention request in 30-day extensions, up to a maximum of four consecutive extensions, or deny the request to retain the waiver slot for the individual when, at the end of this extension time period, there is no evidence of the individual's efforts to utilize waiver services. DBHDS will provide an electronic response to the Support Coordinator indicating denial or approval of the slot extension request within 10 working days of the receipt of the request for extension. The Support Coordinator will notify the individual and family/caregiver, as appropriate, in writing of any denial of the slot extension request and the individual's right to appeal.

Waiver Required Assessment

Each individual who receives DD waiver services is required to have an assessment that gathers information about the individual's patterns and intensity of needed supports across life activities. The results of this assessment are used in the person-centered planning process, along with other

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assessment information from doctors, psychologists and other professionals to develop each individual's ISP.

The SIS[®] is one such assessment tool. It identifies the practical supports required by individuals who are enrolled in a waiver to live successfully in their communities, specifically assessing individuals' support needs in regards to:

- Home living activities;
- Community living activities;
- Lifelong learning;
- Employment;
- Health, safety, social activities, and self-advocacy;
- Medical and behavioral support needs; and
- What is important to and important for individuals.

The Supports Intensity Scale-Children's Version[™] (SIS-C)[™] may be used for individuals who are five years through 15 years of age. The Supports Intensity Scale-Adult Version[™] (SIS-A)[™] is used for individuals who are 16 years of age and older. Individuals who are younger than five years of age are assessed using an age-appropriate standardized living skills assessment. The SIS is administered and analyzed by qualified, trained vendors designated by DBHDS.

A SIS assessment and the Virginia Supplemental Questions (VSQ), as appropriate, will be completed with the individual and others, such as family members and staff, who have known the person for at least 3 months and have knowledge of the individual's circumstances and needs for support.

The SIS or other developmentally appropriate assessment is completed according to the following regular schedule:

- At least every four years for those individuals who are 22 years of age and older;
- At least every three years for those individuals who are 16 years of age through 21 years of age;
- Every two years for individuals five years through 15 years of age when the individual is using a tiered service, such as group home residential, sponsored residential, supported living residential, group day, or community engagement. Another developmentally appropriate standardized living skills assessment approved by DBHDS, such as the Brigance Inventory, Vineland, or Choosing Outcomes and

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Accommodations for Children will be obtained every two years for service planning purposes for those in this age grouping who are not using a tiered service; or

- For children younger than five years of age, an alternative industry assessment instrument approved by DBHDS, such as the Early Learning Assessment Profile, will be completed by the appropriate professional every two years for service planning purposes.

When there is documentation that an individual's support needs have changed significantly for a sustained period of at least six months, the Support Coordinator may request a SIS reassessment outside of the above regular cycle by completing the Virginia SIS Reassessment Request form and submitting it along with documentation of the need for reassessment to the DBHDS Regional Supports Specialist.

Approved requests will result in the scheduling of a new SIS assessment. Scores from SIS-A™ and SIS-C™ Section 1 (Medical, Behavioral), Section 2, Subsections A, B, and E, and responses to Supplemental Questions will be used to assign levels of supports (levels 1 – 7) to each individual.

The Virginia Supplemental Questions will also be used to identify individuals who have unique needs falling outside of the needs identifiable by the SIS instrument. The VSQ will also be administered and analyzed by the same qualified, trained vendors designated by DBHDS.

The Virginia Supplemental Questions addresses the following topics:

- Severe medical risk,
- Severe community safety risk for people with a related legal conviction,
- Severe community safety risk for people with no related legal conviction,
- Severe risk of harm to self, and
- Fall risk.

Specified affirmative responses to the items in the bullets directly above require a review of the individual's record for verification. After such review, the individual may be assigned to Level 6 (Intense and Significant Medical) or Level 7 (Intense and Significant Behavioral) regardless of scoring on other sections of the SIS.

LEVELS OF SUPPORT AND REIMBURSEMENT TIERS

The results of the SIS, Virginia Supplemental Questions, and, as needed, the document review verification process determine the individual's required level of supports. Levels of supports are described as:

- Level 1 indicates low support needs;
- Level 2 indicates low to moderate support needs;
- Level 3 indicates moderate support needs plus some behavior challenges;
- Level 4 indicates moderate to high support needs;

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- Level 5 indicates maximum support needs;
- Level 6 indicates intense and significant support needs due to medical challenges, and;
- Level 7 indicates intense and significant support needs due to behavioral challenges.

An individual's level of support determines his reimbursement tier for certain services so that providers are reimbursed for services provided to individuals consistent with that level of support as follows:

- Tier 1 is used for individuals having Level 1 support needs.
- Tier 2 is used for individuals having Level 2 support needs.
- Tier 3 is used for individuals having Level 3 or Level 4 support needs.
- Tier 4 is used for individuals having Level 5, Level 6, or Level 7 support needs.

REEVALUATION OF SERVICE NEED AND ONGOING SUPPORT COORDINATOR MONITORING

The Support Coordinator is responsible for continuously monitoring the appropriateness of the individual's services and making timely revisions to the ISP as indicated by the changing needs of the individual. Any modification to the amount or type of services in the ISP must be authorized by DBHDS.

The Support Coordinator must monitor the providers' Plans for Supports to ensure that all providers are working toward the desired outcomes with the individual being supported.

Support Coordinators are required to conduct and document evidence of monthly onsite visits for all individuals enrolled in the DD Waivers who are residing in VDSS-licensed assisted living facilities or approved adult foster care homes.

Support Coordinators must conduct and document a minimum of quarterly face-to-face visits with all other individuals with at least one visit annually occurring in the home.

All requests for an individual to receive increased DD waiver services must be reviewed by the Support Coordinator to ensure that the increase is needed to assure the individual's health, safety, and welfare in the community, based on appropriate assessment criteria as supported by the Plan for Supports, and that those services can be safely and cost effectively provided in the community.

QUARTERLY REVIEWS AND ANNUAL REEVALUATION OF SERVICE NEED

The Support Coordinator must review the ISP at least quarterly to determine whether the individual's desired outcomes and support activities are being met and whether any modifications to the ISP are necessary. The person-centered quarterly review must also include documentation regarding the individual's and the individual's family's/caregiver's, as appropriate, satisfaction with services. The results of such reviews must be documented, signed, and dated in the

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individual's record even if no change occurred during the review period. This documentation will be provided to DMAS and DBHDS upon request.

The Support Coordinator must complete a reassessment at least annually, in coordination with the individual and the individual's family/caregiver, as appropriate, providers, and others as desired by the individual. The reassessment must be signed and dated by the Support Coordinator and include an update of the level of care (VIDES), personal profile, risk assessment, and any other appropriate assessment information. The VIDES must be updated within a year of the last completed VIDES, with an allowance of completion by the end of the month in which it is due or up to two weeks into the next month, if the due date is at the end of a month. The updated VIDES must be completed prior to or during the ISP meeting in order to confirm continued functional eligibility. If the updated VIDES demonstrates that the individual no longer meets waiver requirements, the Support Coordinator must inform DMAS and DBHDS via WaMS that the individual must be terminated from waiver services, following notification of appeal rights.

The ISP will be revised at this annual juncture in the context of a person-centered planning meeting for consistency with all updated reassessment information. There must be no more than 365 days between ISP dates (366 in a leap year).

Other updated assessments may include:

- A medical examination as needed for adults and according to the recommended frequency and periodicity of the EPSDT program (12VAC30-50-130) for children ages birth to 21 years,
- A new psychological or other diagnostic evaluation completed by a qualified examiner as previously described whenever the individual's functioning has undergone significant change (meaning a change in an individual's condition that is expected to last longer than 30 calendar days but does 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, such as deterioration of abilities that is expected to last longer than 30 days, and is no longer reflective of the past evaluation).

CUSTOMIZED RATE

Individual-specific support needs, such as the extraordinary medical or behavioral supports needs, may warrant customized rates for additional supports delivered by the provider. Customized rates are available for qualifying individuals receiving any of the following waiver services:

- Community Coaching,
- Group Day,
- In-home Support,
- Group Home Residential,

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- Sponsored Residential,
- Supported Living Residential.

To request a customized rate, providers and Support Coordinators must submit to DBHDS a written request for a customized reimbursement rate via the appropriate Customized Rate Initial Application form (available at <http://www.dbhds.virginia.gov/developmental-services/waiver-services>) and accompanying documentation of individual need.

The request will be reviewed by the DBHDS Customized Rate Review Team, made up of clinical and administrative staff to determine that the documentation substantiates the intense needs of the individual, whether medical, behavioral, or both, and that the provider has employed staff with higher qualifications (e.g., direct support professionals with four-year degrees) or increased the ratio of staff-to-individual support of one staff person to one individual (1:1) or, in the case of services already required to be provided at a 1:1 ratio, a two staff persons to one individual (2:1) ratio.

This level of staff intervention allows for appropriate supervision both in the home, as well as in the community to prevent and/or reduce social isolation. Shared staffing ratios in these more unique cases (as typically occur in group homes and day services) often do not provide adequate oversight as staff is required to work directly with such individuals to prevent, mitigate, or respond immediately to behavioral incidents, while another staff protects others in the area to ensure all individuals in the setting are safe. In addition, the supervision and oversight required by more experienced/highly trained direct support staff requires clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.

The customized rate methodology will modify the existing rate methodology assumptions for the following components in the existing rate methodologies: additional hours related to increased or specialized staffing supports and program costs.

Customized reimbursement rate determinations may be appealed.

For those individuals approved for customized rates, providers and Support Coordinators must resubmit to DBHDS at least annually the appropriate Customized Rate Annual Application form (available at <http://www.dbhds.virginia.gov/developmental-services/waiver-services>), if continuation of the customized reimbursement rate is sought. The request must include documentation of continued need for a reimbursement rate exceeding the reimbursement rate for the assessed level of support of the individual. The Customized Rate Review Team will review the request to determine whether documentation supports the provider's ongoing receipt of the customized rate. After the review, adjustment determinations for the customized rate may be made. All such adjustment determinations may be appealed.

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INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:

These extremely medically fragile and/or behaviorally challenged individuals are those whose support needs place them in levels six or seven but who have a higher level of need than will be accommodated by the tier four rates, as well as any individual for whom it is determined that the only other resource is to be served out of state, in a state operated mental health or DD facility, or in a more restrictive environment.

They are identified as those who require greater support in order to find in-state providers willing to serve them. These individuals' needs outweigh the resources provided within the current waiver rate structure. Their needs may warrant:

- Increased staffing ratios, and/or
- Higher credentialed staff, and/or
- Increased programmatic oversight.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports.

Behavioral criteria may include, but is not limited to the following:

- The person has a significant behavioral history and/or current behavioral presentation;
- There is a documented high frequency of challenging behavior over the past 6 months;
- The individual has required medical attention due to challenging behavior(s) within the last 90-days;
- The individual is on a restrictive plan because of challenging behavior(s);
- The individual frequently receives PRN medication as a result of challenging behavior(s);
- The challenging behavior(s) in question poses a threat of incarceration, physical injury, or hospitalization;

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- The individual requires 1:1 or 2:1 staffing ratios to actively treat/intervene on challenging behaviors;
- The individual requires staff who have some level of behavioral expertise to work with them- i.e. staff who are able to run more complex training programs, take the lead on implementing token economies or other programs that require a structured schedule of reinforcement based upon contingencies in a behavior support plan;
- There are tangible reinforcers or other materials that are anticipated to have a short shelf life;
- The individual has medical problems that are made worse when the person engages in challenging behaviors such that immediate redirection or blocking is frequently needed; and/or
- The individual targets other individuals such that he/she frequently needs to be separated from group activities and supervised in an alternative area.

Medically, an individual may require 1:1 or 2:1 staff support when he has a health history or recent health complication that puts him at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during meal time due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that he may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff are provided during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as total personal care and the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

Medical criteria may include, but is not limited to the following:

- The individual has a medical diagnosis that requires a specialized plan of care;
- High level staffing supports, specialized training and/or certifications are required to meet the individual's needs or to monitor and report information to health care providers;
- The individual has multiple medical protocols in place with oversight provided by nursing;

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- The individual currently has nursing services in place but the need for increased support is still required to institute medical protocols;
- The individual requires increased supervision and monitoring due to active high risk medical concerns;
- The individual has a history of chronic health support needs that without close monitoring pose a risk to their overall wellbeing;
- The individual's medical condition is expected to worsen/progress with increasing need for support; and/or
- The individual has a history or frequent hospitalizations and/or use of ancillary support such as support provided by a wound care specialist, or Hospice care.

INTERRUPTION OF SERVICES

Temporary Interruption with Continued Eligibility

Whenever all waiver services are interrupted on a temporary basis (e.g., temporary loss of financial eligibility, health and safety at risk in current situation, temporary placement in a rehabilitation hospital, NF, or ICF/IID), for more than 90 consecutive days, the Support Coordinator must notify DBHDS, DMAS and LDSS via a DMAS-225 within 5 business days of service interruption. DSS determines if the individual continues to meet all eligibility requirements for Medicaid. See also the "Delay in Initial Service Initiation/Requests to Retain Slots" section above.

Temporary Interruption with Loss of Financial Eligibility

When DSS determines that the individual is no longer eligible, the Support Coordinator must forward the DMAS-225 to DBHDS. DBHDS will discharge the individual from the DD Waiver and end all active service authorizations. If it is a temporary discharge (no more than 60 days), the Support Coordinator must indicate such on the DMAS-225. Individuals who are not financially eligible for Medicaid will not receive Medicaid funding for DD or ID Targeted Case Management.

Individual Enters an ICF/IID, NF, or Rehabilitation Hospital

When services are interrupted due to an individual entering an ICF/IID, NF, or rehabilitation hospital for temporary services, the Support Coordinator must immediately notify the LDSS eligibility worker by telephone and forward a DMAS-225 to the LDSS and DBHDS explaining the reason for the temporary discharge. The slot must be retained using the Retain Slot function in WaMS if this interruption continues for more than 30 days.

To return to DD Waiver services, the Support Coordinator forwards a copy of the revised DMAS-225 to the LDSS and DBHDS, indicating the start date. The DMAS-225 is then returned to the

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Support Coordinator. In the event that the DMAS-225 is not received by the Support Coordinator in a timely manner, the Support Coordinator may monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. New service authorization requests are required only if there has been a change in waiver, service, service level, or provider.

DISCHARGING AN INDIVIDUAL FROM DD WAIVER SERVICES

DMAS and DBHDS will ensure only eligible individuals receive DD waiver services and will remove the individual from the waiver and close all services when the individual is no longer eligible for the waiver. Discharge from the DD Waivers must occur when:

- The individual's health, safety, and welfare and medical needs can no longer be safely met in the community;
- The individual is no longer eligible for either Medicaid or no longer meets the ICF/IID level of care or diagnostic eligibility;
- The individual was eligible for one of the waivers and accepted a waiver slot but did not start services for five months;
- The individual moves to another state;
- The individual declines DD waiver services;
- The individual enters an ICF/IID, NF, or rehabilitation hospital;
- The local department of social services determines that the individual is no longer financially eligible;
- HCBS are not the critical alternative to prevent or delay ICF/IID placement;
- An appropriate and cost-effective ISP cannot be developed; or
- The individual is deceased.

To discharge an individual from a DD Waiver the Support Coordinator must complete a DMAS-225, which terminates all DD Waiver services, and must notify all providers. The DMAS-225 is sent to the LDSS clearly noting the date of discharge and the reason for the discharge. The Support Coordinator must notify DBHDS, DMAS and DSS within 5 business days when an individual is discharged from DD waiver services. The Support Coordinator is responsible for ending all active service authorization lines in WaMS and clearly noting the reason for discharge in the "note" section of WaMS. Once all active lines have been ended by DBHDS, the individual's assignment

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to the slot will be promptly terminated in WaMS by the Support Coordinator (following offering appeal rights to the individual and family/caregiver, as appropriate). The CSB will then contact the DBHDS Regional Supports Specialist to request reassignment of the slot via the Waiver Slot Assignment Committee (WSAC) process.

Once an individual is discharged from a DD Waiver, should he/she wish to again receive DD waiver services, the individual must reapply for a DD Waiver.

Transferring Support Coordination/DD Waiver Slots

If an individual receiving waiver services moves or intends to move into a new catchment area, the CSB/BHA of origin must, as soon as practical, contact the receiving CSB/BHA in the new catchment area to inform them. This can be completed via a secure email, phone call, or voicemail. This initial contact is considered a courtesy and is not considered an official request to transfer. However, this initial communication leads to a smooth transition and is recommended. Once the CSB/BHA of origin believes an individual's services are stable, this CSB/BHA must begin the transfer process unless one of the following conditions is met:

- The individual and family/caregiver, as appropriate, has expressed a choice to continue support coordination/case management services with the current CSB/BHA, and the current CSB/BHA is willing and able to provide or contract for support coordination/case management and can demonstrate the capacity to handle emergency situations. If the CSB/BHA of the individual's residence must provide DD emergency/crisis services (vs. mandated mental health emergency/crisis services) at any time, support coordination/case management and the waiver slot will be transferred within 30 days to the CSB/BHA in which the individual resides. In this instance, the current CSB/BHA will be deemed unable to provide support coordination/case management services; or
- The placement in another CSB/BHA service area is temporary (90 days or less).

The formal support coordination transfer process is initiated by a letter that is sent from the DD Director (or designee) from the CSB/BHA of origin to the receiving DD Director (or designee) of the receiving CSB/BHA. This letter is typically accompanied by the most recent versions of the following supplemental documentation, as appropriate for the individual:

- DMAS 225 and information to indicate case has been transferred to the new CSB;
- Patient Pay letter designating collecting provider;
- Individual Support Plan (Parts I-V);
- Quarterly reports from current ISP year;
- Six months of progress notes;
- All provider Plans for Supports and related schedules (Part V);

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- Virginia Informed Choice Form;
- Confirmation of diagnosis of developmental disability that comports with the definition of DD at § 37.2-100;
- VIDES;
- SIS;
- Recipient Choice form;
- Risk Awareness Tool (RAT);
- Crisis Risk Assessment Tool (CAT or CRAT);
- On-site Visit Tool (OSVT);
- RST referral (if criteria is met);
- Guardianship/POA documents, recent capacity evaluations; and
- Initial DARS letter or progress note documenting unavailability of DARS funding.

Not all transfers will require each document to be submitted. It is incumbent on the receiving CSB/BHA to review documentation and ensure all necessary documentation has been received. Once the receiving CSB/BHA has reviewed the documents and accepted the transfer, the receiving CSB/BHA will send a letter back to the CSB of origin accepting the transfer and confirming the date of transfer.

On the date of transfer, the CSB/BHA of origin is responsible for transferring the individual's records in all electronic systems (such as WaMS or SIS Online).

If support coordination for an individual receiving waiver services is transferred from one CSB/BHA to another, the waiver slot for that individual will also be transferred to the new CSB/BHA and becomes part of its pool of available waiver slots.

DD and ID SUPPORT COORDINATION / CASE MANAGEMENT SERVICES

There are two different forms of Support Coordination for individuals with developmental disabilities: Support Coordination for individuals with intellectual disability and support coordination for individuals with developmental disabilities other than intellectual disability. Both are State Plan Option Targeted Case Management services and may be provided to individuals who receive DD waiver supports and, in some circumstances to individuals who are not DD waiver recipients.

INDIVIDUAL ELIGIBILITY FOR ID/DD TARGETED CASE MANAGEMENT (SUPPORT COORDINATION)

Individuals are eligible for **ID support coordination** if they are Medicaid eligible and have an intellectual disability as defined in § 37.2-100 of the Code of Virginia. This states:

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"Intellectual disability means a disability, originating before the age of 18 years, characterized concurrently by (i) significant sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

Any individual who meets the above diagnostic and general Medicaid eligibility criteria and there is an individual support plan (ISP) in effect that requires direct or individual-related contacts or communication or activity with the individual, the individual's family or caregiver, service providers, significant others, and others including at least one face-to-face contact with the individual every 90 days is eligible for ID support coordination. Billing can be submitted for such an "active" individual only for months in which direct or individual-related contacts, activity, or communications occur, consistent with the ISP. The individual may be receiving DD waiver services, be on the DD waiver waiting list, or require only active support coordination services.

Individuals are eligible for **DD support coordination** if they are Medicaid eligible, have a developmental disability as defined in § 37.2-100 of the Code of Virginia below and are enrolled in one of the DD waivers or are on the DD waiver waiting list and have a "special service need."

"Developmental disability means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life."

If a *special service need* is identified for an individual on the DD waiver waiting list, an ISP must be developed to address that need. A special service need is one that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, behavioral, and medical needs or provide assistance related to an acute need that coincides with support coordination allowable activities (see below). Support coordinators must make face-to-face contact with the individual at least every 90 calendar days to monitor the special service need, and documentation is required to support such contact. If an activity related to the special service need is provided in a given month, then the support coordinator would be eligible

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for reimbursement. Once the special service need is addressed related to the specific activity identified, billing for the service may not continue until a special service need presents again. Examples of special service needs for people with DD who are waiting for waiver services could include:

- A child with autism on the waiting list needs to access behavioral services;
- An adult experiences the loss of a family caregiver and needs to look for alternate housing;
- Following a stroke an adult needs to locate specialized medical services to transition back to their home;
- A family member reports a child on the waiting list has experienced changes in his health, status and needs to explore options to avoid placement in an institutional setting;
- A young person is transitioning out of school and needs to access vocational rehabilitation or employment services;
- A young woman who has limited contact with family begins experiencing seizures and needs to support to locate a neurologist;
- New neighbors move into a person's neighborhood resulting in escalating conflict between the person with DD and the neighbors.

An individual who is receiving active DD support coordination is a person for whom there is an individual support plan (ISP) that requires direct or individual-related contacts or communication or activity with the individual, the individual's family/caregiver, service providers, and significant others. Billing can be submitted for an active individual only for months in which direct or individual-related contacts, activity, or communications occur, consistent with the desired outcomes in the individual's ISP. Face-to-face contact between the support coordinator and the individual must occur at least every 90 calendar days in which there is an activity submitted for billing.

In the following sections, areas of distinction between ID support coordination and DD support coordination will be highlighted. Areas of commonality will be presented as such.

Service Definition/Description:

Support coordination services are activities designed to assist an individual with DD in accessing and maintaining needed medical, psychiatric, social, educational, employment, residential, and other supports essential for living in the community and in developing his or her desired lifestyle. While support coordination is available to some individuals who do not receive DD waiver

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services, as detailed above, all individuals receiving DD Waiver services must receive either DD or ID support coordination services.

Support coordination services covered under the Medicaid Program do not require service authorization. The support coordination provider must meet all applicable standards and policies. It is the responsibility of the CSB/BHA to assure individuals' ongoing eligibility and need for support coordination services.

Criteria/Allowable Activities:

A person who receives support coordination services must have a person-centered Individual Support Plan (ISP) in effect which requires at least a monthly direct or individual-related contact, communication or activity with the individual, family / caregiver, service provider(s), or significant others, including at least one face-to-face contact with the individual every 90 days. A 10 day grace period is permitted for the face-to-face contact; however, if the grace period is used, it does not change the original 90 day due date.

The assigned support coordinator must provide support coordination services as frequently and timely as the person needs assistance. There must be at least one documented contact, activity, or communication, as designated above, and relevant to the ISP, during any calendar month for which support coordination services are billed.

The activity of writing the ISP, person-centered review, or case note is not considered a billable support coordination activity. Developing the ISP through a team meeting or reviewing other providers' written materials in order to prepare the support coordination person-centered reviews are billable activities. Accompanying individuals to appointments or transporting them is not covered. While transportation may be a naturally occurring event to facilitate another, billable, activity, transportation alone cannot be used for billing purposes.

Support coordination services allowable activities provided to eligible individuals include:

- Assessment and planning services to include a comprehensive initial assessment and periodic reassessment (at least annually) that is completed face to face with the individual, to determine the need for any medical, behavioral health, educational, social or other services/supports. This does not include performing medical and psychiatric assessment, but does include referral for such assessments when indicated to determine the individual's medical and behavioral needs. These assessment activities include:
 - Taking the individual's history;
 - Identifying the individual's needs, including known and potential risks;

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- Gathering information from other sources such as family members; medical, behavioral health and other service providers; social workers; and educators (if applicable), to form a complete assessment and ongoing reassessment of the individual within the individual's cultural context;
- Completing related documentation, and
- Providing all required respondent information to the SIS vendor within 10 business days of the date it is requested or scheduling another developmentally appropriate assessment for children under the age of five or for five through 15 year olds who do not receive tiered services.
- Person-centered service planning that includes development of a shared ISP in accordance with the requirements of the HCBS settings regulations (42 CFR 441.725) and periodic revision of the ISP that is based on the changing needs of the individual, transitions in the individual's life, and information collected through ongoing assessment that:
 - Working with the individual and family / caregiver / representative or guardian and others, specifies measurable outcomes and actions to address the known and potential medical, health and behavioral risks, social, educational, and other services and supports needed by the individual, and addresses risk mitigation to pursue the life the individual wants; and
 - Includes provider-specific (including the support coordinator) plans for support activities that ensure the individual's active participation to and identify a course of action to respond to the assessed needs, including medical, health and behavioral risks, and preferences of the individual.
- Linking individuals to medical, social, educational providers, or other supports and services, including referral and related activities (such as scheduling appointments for the individual, facilitating communication) that are indicated to address identified needs and preferences and achieve outcomes specified in the ISP;
- Monitoring and follow-up to assess ongoing progress and ensure that services are being delivered as outlined in the ISP, as well as to address any change of status:
 - Conducting necessary activities and contacts to ensure the ISP is implemented and adequately addresses the individual's needs. These contacts may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, but at least monthly, to assess the quality of supports delivered and satisfaction of the individual and to determine whether the following conditions are met:

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- The individual's health status, any medical conditions, medications and potential side effects are known and monitored and the individual is assisted in accessing primary care and other medical services;
 - Services and supports are being furnished at the level and frequency described in the individual's ISP; and
 - Services and supports identified in the ISP are adequate to meet the individual's needs.
- Making necessary adjustments to the ISP and service arrangements with providers in response to the individual's needs or status;
 - Conducting face to face meetings, at least once every 90 days (with a 10 day grace period) and at least one time per year in the individual's home, and additionally as dictated by the individual's needs to:
 - Observe and assess for any previously unidentified risks, injuries, needs, or other changes in status;
 - Assess whether the individual's ISP is being implemented appropriately and remains appropriate for the individual; and
 - Assess whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.
 - Convening an annual face to face person-centered planning meeting to review the status of the current ISP, including all provider plans for support. As needed outside the annual review, the support coordinator may convene a meeting(s) to re-evaluate the appropriateness of the plan if the individual's needs have changed significantly; and
 - Conducting quarterly reviews of the ISP and evaluating its effectiveness to determine if progress is being made in meeting the individual's outcomes, if it remains appropriate, and if modifications are needed.
- Coordinating services and service planning with other agencies and providers involved with the individual to include discharge planning and support for other transitions in the individual's life;

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- Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services with other agencies and service providers involved with the individual; navigating the health care system and enhancing community integration by contacting other entities and coordinating services and supports to help the individual develop relationships in the community and participate in vocational, civic, and recreational activities;
- Providing education and counseling which guides the individual and his/her/their family and significant others and develops a supportive relationship that promotes the individual's achievement of outcomes included in the ISP.

Service Limitations

Payments for support coordination services under the State Plan must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Support coordination services which solely include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs are not Medicaid billable.

Both ID and DD Support Coordination may be billed for services provided to Medicaid-eligible individuals who reside in institutions (including those in acute care hospitals, intermediate care facilities for individuals with intellectual disabilities (ICFs/ID), nursing facilities (NF), and psychiatric hospitals that are not institutions for mental diseases (IMDs) for individuals aged 22-64) during the 30 calendar days immediately preceding discharge. The activities of the support coordinator may not duplicate the activities of the institutional discharge planner and may be billed for no more than two 30-day pre-discharge periods within a 12-month period.

DD Waiver and Support Coordination Screening

Upon an individual's presentation to the CSB requesting a Medicaid-covered service (either one available through the DD waivers or support coordination itself), the support coordinator or designated intake staff must meet with the individual and family/caregiver, as appropriate within 60 days of application, to complete an initial assessment prior to or at admission to include:

- Obtaining evidence of a developmental disability;
- Conducting a Virginia Intellectual and Developmental Disability Eligibility Survey (VIDES), if waiver services are being sought; and
- Inquiring if the individual currently has Medicaid.

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The SC uses the above information to determine whether the individual meets admission criteria, assesses the individual's immediate service, health, and safety needs, determines services to meet the individual's identified needs and preferences to the maximum extent possible, explores the use of local community resources available to the general public to meet those needs, and determines whether the CSB has the capability and staffing to provide ongoing support coordination if the individual meets criteria.

Screening for Individuals with ID

If the individual presenting for screening has or likely has a diagnosis of intellectual disability and is Medicaid eligible, the CSB should initiate 90-day assessment ID Targeted Case Management (TCM) to determine eligibility and receive reimbursement for up to 90 days (until eligibility is fully determined). An abbreviated, Plan for Supports may be written and utilized up to the maximum of 90 days for individuals who have not previously received support coordination from any CSB and who do not have diagnostic information necessary to determine eligibility for DD Waiver services. This abbreviated SC Plan for Supports (PFS) should contain:

- Referral information;
- The reason for suspecting the presence of ID; and
- Support activities related to obtaining diagnostic and other assessment information, as well as those related to the need for any ongoing services to include active ID support coordination.

The 90-day SC PFS does not require a person-centered review; however, a final progress note must indicate the results of the 90-day service.

If the individual is or becomes Medicaid eligible and is determined to meet either ID active support coordination service criteria, and is requesting support coordination services, the SC may open the individual to Medicaid ID Targeted Case Management services after developing an annual ISP in compliance with DBHDS Licensure Regulations that address the service need(s).

Screening for Individuals with DD Other than ID

If the individual presenting for screening has or likely has a diagnosis of a non-ID developmental disability (i.e., CP or spinal bifida) or should the diagnosis be unclear, Medicaid reimbursement may be sought directly by the CSB for the screening. CSBs are paid for the screenings at either the state rate or the NOVA rate as set by DMAS. The CSB forwards an invoice on CSB agency letterhead to DMAS which includes:

- The individual's name;
- Social security number;

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- Date of screening; and
- Screening rate (NOVA or ROS).

On a monthly basis, DMAS will collect invoices from CSBs via fax, email or US mail, and determine if the individual identified on the invoices has Medicaid or not. If the individual had Medicaid at the date of the screening, DMAS does not pay for the screening. In such cases, DMAS will contact the CSB to inform them of the individual's Medicaid eligibility. If the individual does NOT have Medicaid at the date of screening, DMAS will forward to internal DMAS reimbursement.

Upon completion of the screening, the CSB makes the determination as to whether the individual is eligible for DD waiver services. Individuals with developmental disabilities, other than intellectual disability, may not receive routine, ongoing support coordination services unless there is a documented special service need, as described earlier in this section.

For both individuals with ID or a DD other than ID, if the individual is determined to be eligible for DD Waiver services, the SC provides choice of either institutional placement or receipt of home and community based waiver services, determines waitlist Priority, places the individual on the DD Waiver waitlist, and provides the individual with appeal rights.

A CSB cannot bill for a DD screening and 90-day TCM in the same month. Upon completion of the screening/eligibility process, the CSB makes the determination if the individual is eligible for Waiver services and/or DD or ID Targeted Case Management (TCM) services, if applicable.

Service Units

The unit of service is one month. Billing for the service may begin with the first face-to-face contact and can be submitted only for months in which at least one direct or individual-related contact, activity, or communication occurs and is documented. Reimbursement is provided only for individuals receiving active support coordination as previously described. There is no maximum number of months that may be billed per year except for those individuals who reside in institutions or medical facilities.

Documentation Requirements

Providers maintain records that document for all individuals receiving support coordination services as follows:

- The name of the individual;
- The dates, times and location of the support coordination;

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- The name of the provider agency (if relevant) and the person providing the support coordination service;
- The nature, content, units of the support coordination services received and whether outcomes specified in the ISP have been achieved;
- Whether the individual has declined services in the ISP;
- The need for, and occurrences of, coordination with other support coordinators and care coordinators;
- A timeline for obtaining needed services; and
- A timeline for reevaluation of the ISP.

The following documentation is required to be completed by the support coordinator:

- An ISP which addresses the individual's support needs and desired outcomes, must be developed, reviewed and updated whenever changes in services are required and at least annually. The ISP and any updates must be retained in the record, document the need for support coordination and be approved, dated, and signed by the individual, authorized representative/guardian, other service providers and the support coordinator.
- The support coordinator must annually coordinate the completion of the Personal Profile (Part I of the ISP), which is a person-centered assessment designed to help the team determine and respond to what works in the person's life and thus needs to be maintained or improved and what does not work and thus needs to be stopped or changed. The Personal Profile may be initiated by the individual's chosen planning partner and completed at the person-centered planning meeting, with the final version distributed to all team members following the meeting. The Personal Profile, along with other relevant social, psychological, psychiatric, medical, and level of care information serves as the basis for development of the ISP and Plans for Supports for all services received by the individual, including support coordination. The Personal Profile summarizes the individual's vision of a good life, their talents and contributions, what is working/what is not working, and what is important to the person in the following life areas:
 - Employment;
 - Meaningful Day;
 - Community Living;
 - Safety and Security;

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- Healthy Living;
- Social and Spirituality; and/or
- Citizenship and Advocacy.

Additionally, the support coordinator annually updates, as needed, the Essential Information (Part II of the ISP), which includes:

- Legal Representation;
 - Disability Determination;
 - Health Information;
 - Behavioral and Crisis Supports;
 - Medications;
 - Physical and Health Conditions;
 - Last Exam Dates;
 - Allergies;
 - Social, Developmental, Behavioral and Family History;
 - Communication, Assistive Technology and Modifications;
 - Education; and
 - Employment,
 - Future Plans,
 - Review of Most Integrated Settings.
- The support coordination Plan for Supports (Part V of the ISP) outlines the support coordination support activities and instructions necessary to carry out the ISP. The support coordination Plan for Supports must contain, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes;
 - The support coordination services to be rendered;
 - A timetable for the accomplishment of the individual's desired outcomes and support activities;
 - The estimated duration of the individual's needs for services;
 - The support coordinator responsible for the overall coordination and integration of the services specified in the Plan for Supports;

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- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations and the requirements of the Home and Community-based Services settings regulations (as found in 42 CFR 441.301).
- Documentation, in the form of unique, person-centered progress notes, must indicate the dates and nature of support coordination services rendered. Documentation of a face-to-face contact every 90 days (with a 10-day grace period permitted) must be in the record. This documentation must clearly state that the support coordinator was in the presence of the individual, assessed and documented his or her satisfaction with services, determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports, including updating the ISP, as indicated.

In conducting face-to-face meetings, support coordinators meet with each individual as dictated by the individual's needs and documentation should reflect:

- Observation and assessment for any potential risks, injuries, needs, or other changes in status;
- Assessment of the status of previously identified risks, injuries, or needs, or other changes in status;
- Assessment of whether the individual's ISP is being implemented appropriately and remains appropriate for the individual; and
- Assessment of whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.
- Support coordinators must complete the On-Site Visit Tool at face-to-face meetings with individuals, no less than one time per quarter. The On-Site Visit tool is used to observe the person and the environment to assess for risks, to document that the person's ISP is implemented appropriately, and to determine if the person has had a change in status that may necessitate an ISP update.
- Support coordinators must complete the Risk Awareness Tool at or prior to the initial ISP meeting and annually thereafter. The Risk Awareness Tool is designed to increase awareness of the potential for a harmful event (e.g., bowel obstruction, sepsis, fall with injury, self-harm, elopement, etc.) to occur and to facilitate the process of taking action to reduce and prevent the risk. Any risks identified must be addressed in the ISP.

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- Support coordinators must complete the Crisis Risk Assessment Tool at intake and at every face-to-face meeting thereafter to capture information that may put an individual at risk for crisis or hospitalization and to foster proactive referrals to the REACH programs if such a risk is determined.
- The ISP must be reviewed via the Person-Centered Review at least every three months beginning from the date of the implementation of the comprehensive ISP. These reviews must evaluate the individual's progress toward meeting the ISP's outcomes and support activities, and the continued relevance of the ISP's strategies and support instructions. As such the review should include relevant information from service providers' person-centered reviews. The support coordinator must update the ISP, if indicated, and implement any updates made. Support coordination quarterly reviews must be added to the individual's record no later than 30 calendar days from the end date of the previous quarter. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/her/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- A new or revised ISP must be developed no more than 365 days (366 in a leap year) from the effective date of the previous ISP.
- The support coordinator must send a "Notice of Action" letter to the individual notifying him/her/them of appeal rights if the individual is denied or found ineligible for support coordination, DD Waiver services or ICF/ID services, placed on the Statewide Waiting List, moved from a higher priority to a lower priority status on the Statewide Waiting List, or services are decreased or terminated.

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- All progress note entries must be signed (first initial and last name minimum) and dated with month, day, and year the described supports were provided. Documentation that occurs after date services were provided must be dated with date the documentation was completed and also include the date the services were provided within the body of the note.
- All relevant communication with the individual, the individual's family/caregiver, as appropriate, providers, DBHDS, DMAS, Department of Social Services (DSS), Department of Aging and Rehabilitative Services (DARS), or other related parties must be documented in the record. This should also include written documentation of contacts made with the individual's physicians, informal service providers, and all professionals concerning the individual.

In addition to the above, for individuals receiving DD Waiver services, the support coordinator is responsible for the following:

- Placing the individual who applies for the DD Waivers and is found to meet the eligibility criteria as defined earlier in this chapter on the DD waiver waitlist if there is no available slot until a slot becomes available.
- Coordinating and maintaining the individual's required medical, diagnostic, psychiatric information, as well as the annual Virginia Individual Developmental Disability Eligibility Survey (VIDES) to document the individual's initial and continued eligibility for DD Waiver services. The annual VIDES must be completed prior to the ISP meeting, but no earlier than 11 months, nor later than 13 months after the previous year's VIDES.

For example, for a 10/1/20 and 10/1/21 ISP:

Previous VIDES	Annual VIDES	Compliant?
8/10/20	8/29/21	Yes – same month
8/10/20	9/7/21	Yes – crosses over a month, but still in 30 day window
8/10/20	9/12/21	No – more than 13 months
8/10/20	7/25/21	No – more than 30 days before annual ISP.

Additionally, if it is completed in the same month as the previous year's VIDES, it will be considered to meet compliance (e.g., 2020 VIDES was completed on August 10th and 2021 VIDES is completed on August 29th). Similarly, if the VIDES is completed no more than two weeks after last year's VIDES and the time frame crosses over from one month to the next (e.g., 2020 VIDES was completed on September 25th and 2021 VIDES is completed on October 7th), that will also be considered acceptable.

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- Maintaining a completed copy of the age-appropriate, DBHDS-approved SIS® or other developmentally appropriate assessment form (depending on the individual's age) and sharing this with waiver services providers.
- For individuals who have a diagnosis of ID (or in rare circumstances - someone who is no longer classified as DD), a new diagnostic assessment must be obtained at such time as the existing assessment fails to reflect the individual's current status, abilities, and adaptive functioning.
- Obtaining medical reassessments as needed for adults according to their health needs and routinely for children less than age 21, in accordance with the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- Maintaining signed and up-to-date Consent to Exchange Information or Release of Information forms (developed by the support coordination provider) for the individual to permit sharing/exchanging information for service coordination.
- Maintaining a current signed copy of the Documentation of Individual Choice between Institutional Care or Home and Community-Based Services (**DMAS 459-C**), indicating the individual's desire for DD Waiver services over institutional services. The completion of this form is initially the responsibility of the support coordinator and is then received annually from DBHDS for each individual on the wait list.
- Maintaining documentation that the choice of provider(s) has been offered on the "Virginia Informed Choice" (**DMAS-460**) form when DD Waiver services are initiated and:
 - Annually;
 - At enrollment into the DD Waiver;
 - When there is a request for a change in waiver provider(s);
 - When new services are requested;
 - When the individual wants to move to a new location and/or is dissatisfied with the current provider;
 - When making a Regional Support Team (RST) referral for individuals with a DD Waiver.

The completion of above form is documentation that the individual was given option of selecting the provider of choice from among those agency and consumer-directed providers meeting the individual's needs. The support coordinator must inform the individual and

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family member/caregiver, as appropriate, of all available enrolled waiver service providers in the community in which he/she/they desires services, and he/she/they will have the option of selecting the provider of choice from the list of enrolled service providers.

- Reviewing all providers’ Plans for Supports to assure that they fulfill all requirements for the particular service offered and address the identified outcomes and support needs before being approved and maintained by the support coordinator. Maintaining an up-to-date copy of the Medicaid LTSS Communication Form (DMAS-225), in the individual’s file. See the “Patient Pay” section of this chapter for more details about support coordinator responsibilities related to the DMAS-225.
- Making monthly onsite visits to individuals receiving any DD Waiver services who reside in assisted living facilities (ALFs) or adult foster care (AFC) homes. Quarterly visits to individuals receiving DD Waiver services who reside in DBHDS-licensed sponsored residential homes are recommended. The visits are to occur when the individual is present. For each individual, the following must be documented in the progress notes:
 - Any issues related to the individual’s health and safety;
 - Individual satisfaction with service delivery and place of residence; and
 - Staff interactions and types of services the individual is receiving while the support coordinator is present.

Reporting unresolved health and safety concerns about ALFs to the DSS Division of Licensing and reporting concerns about AFC homes to the local DSS where the home is located.

- Reporting suspicions of abuse, neglect, or exploitation immediately to the DARS Adult Protective Services (APS) 24-hour toll-free hotline (888-832-3858) or DSS Child Protective Services (CPS) Child Abuse and Neglect hotline (800-552-7096).

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	CORRESPONDING REGULATION(S)	BI	FIS	CL
ADDITIONAL OPTIONS				
Assistive Technology	12VAC30-122-270	✓	✓	✓
Community Guide Services	12VAC30-122-330	✓	✓	✓
Electronic Home-Based Services (EHBS)	12VAC30-122-360	✓	✓	✓
Environmental Modifications	12VAC30-122-370	✓	✓	✓
Individual and Family/Caregiver Training	12VAC30-122-430		✓	
Peer Mentor Services	12VAC30-122-450	✓	✓	✓
Transition Services	12VAC30-122-560	✓	✓	✓

ASSISTIVE TECHNOLOGY (AT)

Service Definition

Assistive Technology is the provision of specialized medical equipment, supplies, devices, controls, or appliances that are not available under the Virginia State Plan for Medical Assistance, which;

- Enable individuals to increase their abilities to perform activities of daily living (ADLs);
- Enable individuals to perceive, control, or communicate with their environment;
- Enable individuals to actively participate in other waiver services that are part of their plan for supports; or
- Are necessary for the life support, including the ancillary supplies and equipment necessary to the proper functioning of such items.

Assistive technology devices are portable and authorized per calendar year.

AT service is available to individuals in the Community Living, Family and Individual Support, and Building Independence Waivers who are receiving at least one other waiver service.

Service Requirements & Criteria

In order to be eligible for AT, an individual must have a demonstrated need for a device/equipment that provides remedial or direct medical benefit in the individual's primary residence, primary vehicle, community setting or day program to increase his ability to control his environment, support ISP outcomes as identified, and live safely and independently in the least restrictive community setting.

Allowable equipment and activities may include:

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

Equipment, supplies, or technology not available as durable medical equipment through the State Plan for Medical Assistance may be purchased and billed as the AT service as long as the request for the item is documented and justified in the individual's ISP, recommended by the support coordinator, service authorized, and provided in the least expensive, most cost-effective manner possible.

For each AT request and prior to DMAS designated SA contractor approval:

- An independent, professional consultation/evaluation to determine the needs of the individual must be obtained from a qualified professional who is knowledgeable of that item;
- A prescription alone does not meet the standard of an evaluation;
- All evaluations must be signed by the qualified professional;
- Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists.

Examples Assistive Tech. Devices/Equipment (not a comprehensive list)	Professional Evaluation Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces	Physical Therapist or Physician
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist

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Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occ. Therapist; depending on device or equipment
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist or Behavioral Consultant

If needed, contact DMAS or its service authorization contractor for assistance with determining the appropriate professional making the recommendation. Items such as furniture shall not be approved if they are of general utility and are not of direct medical benefit.

The AT provider's quote must be compatible with the evaluation completed by the qualified professional. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be utilized if, for example:

- The Assistive Technology will be initiated in combination with Environmental Modifications involving systems which are not designed to go together; or
- An existing device must be modified or a specialized device must be designed and fabricated.

Service Units and Service Limitations

- The service unit is always one, for the total cost of all AT requested for a specific timeframe. The service unit is the total cost of the item and any supplies, or hourly Rehabilitation Engineering costs;
- Providers of AT may not be the spouse, parent (natural, step, adoptive, or foster) or legal guardian of the individual who is receiving waiver services;
- Providers that supply AT for the individual may not perform the professional evaluation or write specifications for that individual;
- Medicaid will not reimburse for any AT devices or services which may have been rendered prior to authorization from the DMAS designated SA contractor;
- An AT provider's written cost estimate for specific materials related to the AT device must be submitted to the Service Authorization contractor. Any request for a change in cost for any increase in cost requires justification and supporting documentation of need and service authorization by the DMAS designated SA contractor;

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- The AT provider must receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary, then the AT provider must notify the assessor to ensure the changed items meet the individual's needs;
- The maximum Medicaid-funded expenditure per individual for all AT covered procedure codes combined is \$5,000 per calendar year and the delivery of the service must be completed within the calendar year. Unexpended portions of the maximum amount may not be carried over from one calendar year to the next;
- Each item must be authorized by the Service Authorization contractor prior to providing the service and cannot be authorized retroactively. The service authorization will not be modified to accommodate delays in product deliveries. In such situations, new service authorizations must be sought by the provider;
- Computer software purchased for an individual must be owned by the individual and accessible by the individual and/or caregiver, as appropriate, to make changes, download updates, etc.;
- All products must be delivered, demonstrated, installed and in working order prior to submitting any claim to Medicaid. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates;
- When two or more individuals receiving waiver services live in the same home, the AT must be shared to the extent practicable consistent with the type of AT;
- AT for individuals younger than 21 years of age must be accessed through the EPSDT benefit;
- All AT service items to be covered must meet applicable standards of manufacture, design, and installation;
- The provider must provide all warranties or guarantees from the AT manufacturer to the individual and family/caregiver, as appropriate.

Service Exclusions

- AT is not covered for purposes of convenience of the caregiver or paid staff, restraint of the individual receiving the waiver, or for recreational or leisure purposes. Such items not covered include, but are not limited to, swing sets, playhouses, bowling balls, tricycles/bicycles, trampolines, television sets, video equipment/games, computer games, playing cards, printers, scanners, sporting equipment, general exercise equipment.

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- AT equipment and supplies may not be rented but must be purchased through an AT provider,
- DMAS will not repurchase items purchased with AT funds unless those items have specific time-limited usefulness (e.g., computer/electronic tablets - 5 years),
- Only the actual cost of material attributed to the provider of the AT is reimbursed. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered all-inclusive in a provider's charge for the item(s),
- Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Assistive Technology. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B*. at: www.virginiamedicaid.dmas.virginia.gov/wps/portal.
- No duplication of payment for the AT service is permitted between the waiver and services covered for adults that are reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 12101 et seq.), the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia), and the Rehabilitation Act (29 USC § 701 et seq.).

AT maintenance entails the upkeep or installation of an item in order to make or keep the item operational. Some examples, not an all-inclusive list, are the cost of, Smartwatch fees, AT&T Monitoring System, repairing a ceiling lift, "PIE" (bowel management device) machine repairs, replacement screens for iPads with cracked screens or battery changes, repairs and/or the maintenance fee for "Project Life Saver" or "Angel Sense" GPS tracking devices.

Provider Documentation Requirements

The documentation requirements are:

- Documentation of the recommendation for the item by the independent professional consultant.
- The service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of AT service. The service authorization request must be submitted to the SA contractor in order for service authorization to occur. Information to be submitted includes:
 - The need for the service,

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- The process to obtain this service (contacts with potential AT providers or contractors, or both, of service, costs, etc.),
 - The time frame during which the service is to be provided. This includes separate notations of design, supplies, and materials,
 - The Plan for Supports must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved.
- Written documentation ensuring that the item is not covered by the *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies,
 - Documentation of the date services are rendered and the cost of service needed,
 - Any other relevant information regarding the device or modification,
 - Documentation of the individual/PCG's receipt of and satisfaction with the AT provided as well as any training provided to the individual/PCG on the usage of the AT,
 - Documentation in the Support Coordination record of notification by the individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item,
 - Instructions provided to the individual or individual's representative family/caregiver regarding warranty coverage, repairs, servicing, and complaint resolution,
 - Support Coordinators, upon delivery and or installation of AT, must perform and document the results of a face-to-face visit to assure that the individual can use the AT safely and appropriately.

The following accompanying information, as applicable and conducive to the given situation and/or individual's needs:

- Drawings or pictures of items being requested,
- An itemized invoice or estimate,
- The DME denial letter for AT items otherwise covered by DME,
- A description of the individual requiring the item or modification to include age and pertinent disability(ies),

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- Any other relevant information regarding the device or modification.

COMMUNITY GUIDE SERVICES

Service Definition/Description

Community Guide services include direct assistance to promote individuals' self-determination. This service involves coordinating community-based resources that provide a connection to and independent participation in integrated, independent housing and/or community activities to avoid isolation. This means that Community Guides investigate and, as necessary, coordinate, the available, naturally occurring supports and community resources to facilitate the individual's participation in those activities of interest to him/her. Community Guides provide information and direct assistance to help the individual develop supportive community relationships and explore, apply for and maintain community resources that are critical to the implementation of the person-centered plan.

This service primarily involves face-to-face contact with the individual to determine his/her specific interests in community resources and to explore these community resources. Community Guides assist the individual to identify the type of community resources which maximize opportunities for meaningful engagement and growth in independence. The aim is to connect the individual to typical community activities or settings in which the individual will engage or reside and facilitate initial participation in these activities or settings. In addition, there is a component of supporting the individual that may occur without him/her present.

The Community Guide will provide the in-depth assistance needed to connect with community resources, activities, and foster engagement distinct from the generic activities provided through routine support coordination. This service is designed to be short-term and periodic in nature.

Criteria/Allowable Activities

There are two different types of Community Guide services:

- General Community Guide:

This service type involves utilizing existing assessment information regarding the individual's general interests to determine specific preferred activities and venues available in the community to which the person desires to be connected to promote inclusion and independent participation in the life of his/her community. Examples of activities include clubs, special interest groups, physical activities/sports teams, etc. The desired result is an increase in daily or weekly natural supports, as opposed to increasing hours of paid supports.

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Allowable activities are listed below. These activities must be in the individual's Plan for Supports.

- Utilize assessment and other information provided by the Support Coordinator along with an in-depth discussion with the individual and family/friends to develop a plan, separate from the Plan for Supports, which:
 - Outlines the individual's interests,
 - Contains a step by step strategy to reduce barriers and challenges in accessing community resources/activities to support those interests,
 - Identifies targeted actions that will build upon these interests to promote community integration and independent or naturally supported involvement.
- Assist the individual with connecting to the identified, non-Medicaid funded community resources by researching and contacting the parties responsible for the identified integrated activities, supports, services, and/or resources delineated in the individual's plan,
- Provide advocacy and informal counseling to help guide the individual in problem solving and decision making and enhance his/her ability to interact with and contribute to the local community,
 - Escort the individual and/or demonstrate on site how to access the identified integrated community activities, supports, services, and/or resources,
 - Follow up with the individual to assess and document his/her participation in or utilization of the activities, supports, services and/or resources to which the Community Guide assisted in connecting.
- Community Housing Guide:
 - This service involves supporting an individual's move to independent housing by helping with transition and tenancy sustaining activities. The Community Housing Guide will work in collaboration with the Support Coordinator, DBHDS Regional Housing Coordinator, landlords and others to support the individual with accessing and sustaining integrated, independent housing. Independent, integrated housing means that the individual has a mortgage or lease in his/her own name (e.g., the person is a tenant); the individual does not live with his/her parent, grandparent or

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guardian; and the individual's housing is separate from services (e.g., the individual does not live in a licensed or provider-controlled setting).

Allowable activities are listed below. These activities must be in the individual's Plan for Support.

Conduct a tenant screening using the Community Housing Guide Tenant Screening form (DMAS-P-263) that identifies the individual's housing needs and preferences, and barriers related to successful tenancy;

Develop a plan, which is separate from the Plan for Supports and called a Housing Road Map (DMAS-P262) that outlines the activities the Community Housing Guide and others who support the individual will perform to identify and secure safe, affordable housing. Activities will include assisting the individual with plan implementation and making recommendations to the Support Coordinator for waiver support services and community resources needed in the Individual Support Plan;

- Assist with the housing search process by contacting the identified resources that meet the individual's needs and preferences outlined in the Tenant Screening including administrators of rental assistance, public housing agencies, housing providers, and other entities with housing resources,
- Assist the individual with applying for rent assistance and/or housing by contacting housing providers, attending appointments with housing providers to view apartments, and assisting the individual to complete applications for rental housing,
- Help identify and facilitate the individual's request for resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses needed to obtain housing,
- Assist in arranging for and coordinating the details of the move to independent housing (e.g., arranging for a moving company, securing help to pack/unpack, setting up utility services, obtaining renter's insurance, changing address at the post office, etc.),
- Provide education and training on the role, rights and responsibilities of the tenant and landlord during the transition from home or congregate setting as needed during the tenancy,
- As part of the transitional support activities, provide training in responsible tenant behavior and lease compliance; and provide support with activities related to household management

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(e.g., operating and maintaining appliances and heating/cooling systems, using the mailbox, submitting requests for repairs, paying rent and utilities),

- Assist in resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse action such as lease violation during the period of time that community guide services are authorized,
- Assist with the housing program's recertification process, if or when requested by the Support Coordinator or the individual's support team, and
- Assist in arranging for and supporting the details of a subsequent move to another independent housing setting.

Service Limitations

No more than twenty-five percent of authorized Plan for Supports hours may consist of Community Guide activities conducted without the individual present, such as researching and contacting potential sites, housing properties, supports, services and resources.

The Community Guide will not supplant, replace, or duplicate activities that the Support Coordinator is required to provide. Prior to accessing funding for this waiver service, all other available and appropriate funding sources, including those offered by Virginia Medicaid State Plan, DARS, and DOE, will be explored and exhausted. It is the provider's responsibility to ensure adequate documentation that service is unavailable through other means.

Service Units

Community Guide is expected to be a short, periodic, intermittent, intense service associated with a specific outcome. An individual may receive one or both types of Community Guide services in an ISP year. The cumulative total across both types of Community Guide services may be no more than 120 hours in an ISP year. In general, each type of Community Guide service may be authorized for up to six consecutive months; however, if after six months, the 120 hour ISP year limit has not been reached and further supports are still required, a request for additional months of Community Guide services may be submitted for service authorization.

If it becomes apparent mid-month that a Community Guide provider is likely to exceed the monthly authorized amount of services, yet still has not reached the annual limit, the provider may request an increase in hours for that month. The provider is still limited to the annual 120 hour per ISP year maximum.

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Service Documentation Requirements

Providers will include in each individual's record:

- A completed copy of the age-appropriate DBHDS-approved SIS® assessment form,
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms,
 - Support activities and support instructions that are inclusive of skill-building as may be required by the service provided and that are designed to assist in achieving the individual's desired outcomes,
 - The services to be rendered and the schedule of 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,
 - The provider staff responsible for overall coordination and integration of the services specified in the plan for supports, and
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.
- Documentation must correspond with billing. Providers must maintain separate documentation for both face-to face and collateral activities, for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note or if service is provided less than daily, observations of individual responses to the service must be available for each specific

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service date. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- For Community Housing Guide, the provider should retain:
 - A copy of any rent assistance eligibility (e.g., voucher, certificate),
 - A copy of the rent assistance participation agreement,
 - A copy of the individual's lease,
 - Copies of lease violation notices and rent assistance program violation notices,
 - A copy of the Community Housing Guide Tenant Screening and Tenant Roadmap forms (DMAS-P262).
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - Description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted:
 - Information about any newly identified safety risks,
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services.
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason, and
 - Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either

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by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion,

- Documentation that all other available and appropriate funding sources, including those offered by Virginia Medicaid State Plan, DARS, and DOE, as appropriate, have been explored and exhausted,
- All correspondence to the individual and the individual's family/caregiver, as appropriate, the Support Coordinator, DMAS, DBHDS, and, for Community Housing Guide, relevant housing providers,
- Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual,
- For the annual review (should the service span across two ISP years) and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate,
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

ELECTRONIC HOME-BASED SUPPORTS (EHBS)

Service Definition

Electronic Home-Based Supports or “EHBS” provides technology solutions that allow individuals to more safely live in the home environment, and/or achieve greater independence, self-determination, and community inclusion, and/or decrease the need for other Medicaid services, such as reducing the need for staff supports. EHBS may include current SMART Home technologies, purchasing of electronic devices, software, services, equipment, and supplies not covered through the Waiver or through the State Plan for Medical Assistance. EHBS includes portable hand held devices used at home or while in the community. EHBS items and services should be designed to support:

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- Increased safety in the home environment;
- Increased independence, self-determination, or community inclusion; and
- Decreased need for other Medicaid services, such as reliance on staff supports.

The EHBS is a covered service in the Community Living, Family and Individual Supports and Building Independence waivers.

Criteria

Individuals who qualify for this service must be at least 18 years of age and capable of using the equipment provided through this service.

A preliminary needs assessment must be completed by an independent professional consultant to determine the best type and use of technology and overall cost effectiveness of various options to include consideration of how the designs will optimize the outcomes for individuals. The results of the assessment should be submitted with the service authorization request prior to the delivery of any goods and services and prior to the submission of any claims for Medicaid reimbursement.

The independent professional consultant conducting the preliminary assessment may be an Occupational Therapist, Behavior Specialist or 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.

EHBS service will support training in the use of these goods and services, ongoing maintenance, and monitoring to address an identified need in the individual's ISP, including improving and maintaining the individual's opportunities for full participation in the community.

Items or services purchased through EHBS service should 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.

Service Units and Service Limitations

- The ISP year limit for this service is \$5,000. No unspent funds from one plan year may be accumulated and carried over to subsequent plan years,
- Receipt of EHBS service may not be tied to the receipt of any other covered waiver or Medicaid service,
- Equipment /supplies already covered by any other Medicaid covered service must be excluded from coverage by this waiver service,

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- EHBS service must be provided in the least expensive manner possible that will meet the identified need of the individual enrolled in the waiver and must be completed within the individual's ISP year,
- This service is not covered for those individuals receiving residential supports reimbursed on a daily basis, such as group home, sponsored residential, or supported living services.
- The EHBS provider must receive a copy of the assessment in order to purchase the equipment/supplies recommended by the professional consultant. If a change is necessary then the EHBS provider must notify the professional consultant to ensure the changed items meet the individual's needs.

Service Documentation Requirements

- Required service documentation in each individual's record must include signed and dated documentation of the following:
 - The appropriate service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of EHBS service. A rehabilitation engineer may be involved for EHBS service if disability expertise is required that a general contractor may not have. The service authorization request documentation must include justification and explanation if a rehabilitation engineer is needed. The service authorization request must be submitted to the state-designated agency or its designee in order for service authorization to occur,
 - Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as durable medical equipment (DME) and supplies, and that the item is not available from a DME provider,
 - Documentation of the recommendation for the item by an independent professional consultant,
 - Documentation of the date service is rendered and the amount of service that is needed,
 - Any other relevant information regarding the device or modification such as product details,

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- Documentation in the support coordination record of notification by the designated individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item, and
- Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

ENVIRONMENTAL MODIFICATIONS (EM)

Service Definition

Environmental modifications or “EM” means physical adaptations to an individual’s home or primary vehicle which are necessary to ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence. The purpose of Environmental Modifications is to modify, not make general improvements to the home. Environmental Modifications are for pre-existing structures.

EM service is available to individuals in the Community Living, Family and Individual Support, and Building Independence Waivers who are receiving at least one other waiver service.

Criteria

To qualify for EM services the individual must have a demonstrated need for modifications to their primary residence or automotive vehicle that specifically improve the individual’s personal functioning and level of independence.

Allowable Activities

- Physical adaptations to the individual’s primary residence that enable an individual to live in the community and to function with greater independence that do not involve additions that increase the square footage of the structure, or
- Modifications to the primary vehicle in which the individual is transported that 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 environmental modifications. This service does not include the purchase or lease of vehicles or general repair of vehicles. Repairs of modifications that have been reimbursed by DMAS may be covered.

Examples of Environmental Modifications

Such modifications may include, but are not necessarily limited to, the following:

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- The installation of non-portable ramps and grab-bars, widening of doorways to accommodate wheelchairs,
- Modification of bathroom facilities to accommodate wheelchairs (but not for strictly cosmetic purposes), or
- Installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies that are necessary for the individual's welfare.

All services provided in the individual's primary residence must be done so in accordance with applicable state or local building codes and appropriate permits or building inspections which must be provided to the DMAS contractor. Medicaid reimbursement may not occur before service authorization of EM services is completed by the DMAS designated SA contractor.

An EM provider and individual might work with multiple providers in order to complete one modification, for example:

- A building contractor may design and complete the structural modification,
- A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor, or
- A durable medical equipment provider enrolled with DMAS may be used to bill for modifications.

Service Units and Service Limitations

- The maximum Medicaid funded expenditure per individual for all EM covered procedure codes (i.e., combined total of EM service items and labor related to these items) combined may not exceed \$5,000 per calendar year for individuals regardless of the waiver for which EM service is approved and regardless of whether or not the individual changes waivers over the course of the calendar year. The service unit will be one for the total cost of all EM being requested for a specific timeframe,
- Costs for EM may not be carried over from one calendar year to the next. Each item must be service authorized by the DMAS-designated agent for each calendar year. Unexpended portions of this maximum amount may not be accumulated across one or more years,
- Only the actual cost of material and labor is reimbursed. There may not be an additional markup,

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- EM must be provided in the least expensive manner possible that will accomplish the modification required by the individual enrolled in the waiver and must be completed within the calendar year,
- Proposed modifications to rental properties must have prior written approval of the property's owner. Modifications to rental properties will only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider,
- Modifications may be made to a vehicle if it is the primary vehicle used by the individual. This service may not include the purchase of, or the routine maintenance of, vehicles (repairs of modifications which have been reimbursed by DMAS may be covered),
- The EM provider will ensure that all work and products are delivered, installed and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim must be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced,
- The service authorization may not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) must be submitted to the DMAS designated SA contractor for revision to the previously issued service authorization and must include justification and supporting documentation of medical needs,
- A copy of the provider's cost estimate (quote) for labor and materials for an environmental modification must be submitted to DMAS designated SA contractor, however, should the cost of the item ultimately reflect a total which is less than the original quote, this will not impede the payment to the contracted entity,
- EM maintenance entails the upkeep or installation of an item in order to make or keep the items operational. Some examples, not an all-inclusive list, are maintenance of the tracks for the chair lift to keep it functional, repairs and/or maintenance to stair lifts, ceiling lifts, and/or lifts in vehicles, repairs to "sesame door," transfers of EM items to new placements (i.e., lifts, bidets), or replacement of the boards on the ramp outside the home to ensure the individual can access the community or home.

EM Exclusions

EM service will encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program, for example, if the Fair Housing Act (42 USC §3601 et seq.), the Virginia Fair Housing Law (§39-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.), the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia), or the Rehabilitation Act (29 USC § 701 et seq.) which requires the modification.

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- There may be no duplication of EM services within the same residence such as multiple wheelchair ramps or previous modifications to the same room. (There may be no duplication of EM within the same ISP year),
- Modifications must not be used to bring a substandard dwelling up to minimum habitation standards. Adaptations or improvements to the primary home that are of general utility and are not of direct medical or remedial benefit to the waiver individual must be excluded, including, but not limited to, the following:
 - Carpeting,
 - Roof repairs, central air conditioning or heating,
 - General maintenance and repairs to a home, additions or maintenance of decks,
 - Maintenance and/or replacement or addition of sidewalks, driveways, carports, or adaptations that only increase the total square footage of the home.
- EM will not be covered by Medicaid for general leisure, or diversion items, or those items that are recreational in nature or those items that may be used as an outlet for behavioral supports. Such non-covered items include, but are not be limited to, swing sets, playhouses, climbing walls, trampolines, protective matting and ground cover,
- EM will not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source,
- Providers of EM must not be the individual's spouse, parent (natural, adoptive, step, foster), legal guardians), other legal guardians, or conservator. Providers who supply EM to waiver individuals must not perform consultations or write EM specifications for such individuals,
- The contractor providing the modification must complete an assessment and quote before performing any work,
- EM is not authorized or allowed for the modification of living arrangements that are owned or leased by providers of waiver services or those living in arrangement that are licensed by a DBHDS provider. Specifically, provider-owned or leased setting where residential supports are furnished must already be compliant with the Americans with Disabilities Act and the CMS Home and Community Based Services regulations settings provision.

Service Documentation Requirements

- The appropriate service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of EM service. A rehabilitation engineer

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may be involved for EM service if disability expertise is required that a general contractor may not have. The service authorization must include justification and explanation if a rehabilitation engineer is needed. The service authorization request must be submitted to DMAS contractor in order for service authorization to occur,

- Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance, for example as durable medical equipment (DME) and supplies and that it is not otherwise available from a DME provider,
- Documentation of the recommendation for the item by an independent professional consultant if an independent professional consultant is required for the individual's needs,
- Documentation of the date services are rendered and the amount of services and supplies,
- Any other relevant information regarding the modification,
- Documentation that the support coordinator, upon completion of each modification, met face-to-face with the individual and the family/caregiver; as appropriate, to ensure that the modifications was completed satisfactorily and is able to be used by the individual,
- Instructions provided to the individual and the family/caregiver; as appropriate, regarding warranty coverage, repairs, maintenance, and complaint resolution.

INDIVIDUAL AND FAMILY/ CAREGIVER TRAINING (IFCT)

Service Description:

Individual and Family/Caregiver Training is the provision of identified training, counseling and education related to disabilities, community integration, family dynamics, stress management, behavior interventions, and mental health to individuals, or families, or caregivers of individuals enrolled in the waiver. The counseling and education provided under this service include assisting the individual with better understanding of his/her disability, increase self-determination and self-advocacy.

DMAS will only reimburse services as defined in the service description, listed in the individual's approved Plan for Supports and that are within the scope of practice of the providers performing the service. (DMAS will not reimburse for training provided through educational courses.)

Criteria

The need for the training, and the training contents, shall assist the individual, family or caregivers with supporting the individual at home. This need must be documented in the individual's ISP.

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The training must be necessary in order to improve the individual, family or caregiver's ability to give or receive care and support.

IFCT must be provided by Medicaid Individual and Family/Caregiver Training providers. Such training may only be billed as it is rendered, for example, billed as individual training when rendered to an individual (including two or more caregivers for the same individual), or billed as a group when rendered to a group of individuals. This service will not duplicate other DD Waivers services. This service shall not cover college classes.

For the purposes of this service, "family" defined as the unpaid persons who live with or provide care to an individual served on the waiver, and may include a parent, legal guardian, spouse, children, relatives, a foster parent, or in-laws. "Family" does not include individuals who are employed to care for the individual. All family training must be included on the individual's ISP.

Service Units and Service Limitations

IFCT services is only available through the Family and Individual Supports Waiver (FIS). Individual and Family/Caregiver Training may be authorized up to \$4,000 per ISP year. Travel expenses, room and board are not covered. Registration fees for the training, conference or seminar are covered under this service. The intent of the Individual and Family/Caregiver Training are not to duplicate any other Medicaid services. IFCT services cannot be authorized retroactively. IFCT services may be rendered via an in-person or telehealth model, based upon the structure of training provided. Any training provided via a telehealth model must include both an audio and visual component.

Service Documentation Requirements

The documentation requirements are:

- The provider's Plan for Supports for Individual and Family/Caregiver Training. This must contain:
 - Identifying Information - The individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for the service; and semi-annual review dates, if applicable,
 - Training services to be provided and the schedule of such services to accomplish the desired outcomes and supports,
 - Verification of training modality (i.e. in person training vs virtual model), and
 - Specific training.

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- Contact notes:
 - Date, location, and time of each training contact,
 - Type of training and hours of training provided, and
 - Persons to whom training was directed.
- Monthly notes:
 - Summary of support/training activities for the month;
 - Dates, locations, and times of service delivery;
 - Plan for supports desired outcome(s) addressed;
 - Specific details of the supports/training conducted;
 - Services delivered as planned or revised; and
 - Effectiveness of the strategies and individuals, families and caregivers' satisfaction with the service.
- Quarterly person centered review are required by the service provider if training extends three months or longer and are to be forwarded to the Support Coordinator and include:
 - Supports related to the Plan for Supports,
 - Individual status and satisfaction with training services, and
 - Desired outcomes and effectiveness of the Plan for Supports.
- If training services extend less than three months, the provider must forward to the Support Coordinator contact notes, monthly notes, or a summary of monthly notes for the quarterly review. The family members who are not directly providing support for the Individual but attended the training/conference, they must include documentation of the registration and details of the training/conference on file,
- Individual and Family Caregiver Training is reimbursed as defined in the service description, listed in the individual's ISP, and that is within the scope of practice of the providers performing the service.

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PEER MENTOR SUPPORTS

Service Definition/Description

Peer Mentor Supports provide information, resources, guidance, and support from an experienced, trained peer mentor to an individual who is a waiver recipient. This service is delivered to waiver recipients by other individuals with developmental disabilities who are or have been service recipients, have shared experiences with the individual, and provide support and guidance to him/her. The service is designed to foster connections and relationships which build individual resilience.

Peer Mentor Supports encourage individuals with developmental disabilities to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with waiver participants so that the waiver participant is better able to advocate for and make a plan to achieve integrated opportunities and experiences in living, working, socializing, and staying healthy and safe in his/her own life, as well as to overcome personal barriers which are inhibiting him/her from being more independent. Peer mentoring is intended to assist with empowering the individual receiving the service.

This service is delivered based on the support needs of the individual as outlined in his/her person-centered plan. This service is designed to be short-term and periodic in nature.

Criteria/Allowable Activities

Allowable activities may include the following for the individual as documented in his plan for supports:

- The administering agency facilitates peer to peer "matches" and follows up to assure that the matched relationship meets the individual's expectations;
- The peer mentor has face-to-face contact with the individual to discuss his/her specific interests/desired outcomes related to realizing greater independence and the barriers to achieving them;
- The peer mentor explains community services and programs and suggests strategies to the individual to achieve his/her desired outcomes, particularly related to living more independently, engaging in paid employment and expanding social opportunities in order to ultimately reduce the need for supports from family members or paid staff;
- The peer mentor provides information from his/her experiences to help the individual in problem solving, decision making, developing supportive community relationships and

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exploring specific community resources that promote increased independence and community integration; and/or

- The peer mentor assists the individual in developing a personal plan for accessing the identified integrated community activities, supports, services, and/or resources.

Contacts between the Peer Mentor and the individual who is receiving the waiver may be in the form of face-to-face or remote technology that allows the Peer Mentor to view the individual and converse with him. The interactive audio/video connection must be of sufficient audio quality and visual clarity so as to be functionally equivalent to a face-to-face encounter, conducted in a confidential manner and any information sharing consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPPA) confidentiality requirements are applicable.

Service Limitations

The Peer Mentor must not supplant, replace, or duplicate activities that are required to be provided by the support coordinator. Prior to accessing funding for this waiver service, all other available and appropriate funding sources must be explored and exhausted.

Peer Mentors cannot mentor their own family members.

Peer Mentors must be at least 21 years of age. This service is only available to individuals 16 years of age and older.

Individuals who receive supports through DD or other waivers may be peer mentors.

Service Units

The unit of service is an hour.

Peer Mentor Supports is expected to be a short, periodically intermittent, intense service associated with a specific outcome. The total number of hours authorized may be no more than 60 hours in an ISP year. In general, Peer Mentor Supports may be authorized for up to 6 consecutive months; however, if after six months, the 60 hour ISP year limit has not been reached and further supports are still required, a request for additional months of Peer Mentor Supports may be submitted for service authorization.

An administrative cost reimbursement is built into the rate for the administering provider.

Service Documentation Requirements

Providers (administering agencies) will include in each individual's record:

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- A copy of the completed, standard, age-appropriate DBHDS approved Supports Intensity Scale®,
- The provider's Plan for Supports, which includes the following required elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable terms,
 - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes,
 - The services to be rendered and a general timetable that states when the planned activities will be accomplished, the estimated duration of the individual's need for services, and the Peer Mentor responsible for the delivery of the services specified in the Plan for Supports.
- Documentation in the form of:
 - A log or similar document that confirms the individual's amount of time in services, the dates of all contacts between the Peer Mentor and the individual with the waiver, as well as information regarding the type of supports delivered to the individual. The log must be signed by the Peer Mentor delivering the service. This documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual,
 - A written review supported by documentation in the individual's record must be submitted to the Support Coordinator quarterly, during any quarters in which the service was provided, with the Plan for Supports, if modified. This written review will list the dates and nature of contacts and a statement about the individual's satisfaction with the service. The quarterly person-centered review is due to the Support Coordinator no later than 10 days following the end of the quarter. For the annual review and every time the Plan for Supports is updated, the revised Plan for Supports will be reviewed with the individual or family/caregiver, as appropriate, and such review must be documented,
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS,
 - Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual,
 - Documentation of the Peer Mentor's qualifications, as well as criminal background and Child Protective Registry (if the waiver individual is under age 18) checks,

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- Administering agency documentation must support all claims submitted for DMAS reimbursement. Claims that are not supported by appropriate documentation are subject to recovery by DMAS as a result of utilization reviews and audits.

TRANSITION SERVICES

Service Definition

Transition Services provide for set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private (community) residence, where the living expenses are the responsibility of the individual. Transition Services may be limited for some community home settings that are already required to provide specific services. Transition Services funds may not be used to supplant or replace existing payment options. The establishment of transition funds are not intended to help with general moving but to aid individuals to successfully live in the community.

Individuals may receive Transition Services through the Community Living, Family and Individual Supports, or the Building Independence waivers. Individuals who leave a qualifying facility, such as Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Diseases (IMD), Psychiatric Residential Treatment Facility (PRTF), Long-Stay Hospital (LSH), or Group Home and demonstrate a need for Transition Services have up to 30 days after transitioning from the qualifying facility (from discharge date) to apply for Transition Services.

For all individuals utilizing Transition Services the SC must include an outcome related to the service in the person-centered ISP prior to seeking service authorization. The service authorization request must include in the SC's justification for the request the name of the institution from which the individual is transitioning, the community housing to which the individual is transitioning, the date of the move, and the list of items/services to be purchased through Transition Services.

Criteria/Allowable Activities

Eligible individuals are those whose health and safety can be maintained in a community setting and who chose to live in a qualified community residence.

Transition services are furnished only to the extent that:

- They are reasonable and necessary as determined through the transition service plan development process,
- They are clearly identified in the transition, matching a demonstrated need,
- The person is unable to meet such expense(s),

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- The goods/services are not the responsibility of another entity, and
- The goods/services cannot be obtained from another source.

This service does not include services or items covered under other waiver service, state plan option, or by other providers.

Allowable costs include, but are not limited to:

- Security deposits and the first month's rent that are required to obtain a lease on a house, condo, apartment or other residence,
- Essential household furnishings and appliances required to occupy and use a community domicile, for example furniture, window coverings, food preparation items, and bed/bath linens,
- Connection or set-up fees or deposits for utility or services access, such as telephone, internet connection, electricity, heating and water,
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy,
- Moving expenses,
- Needed clothing items,
- Fees to obtain a copy of a birth certificate, identification card, or driver's license, and
- Activities to assess need, arrange for, and procure needed resources.

Non-allowable costs include, but are not limited to:

- Reoccurring charges such as monthly rental or mortgage expenses,
- Food,
- Regular/routine utility charges,
- Household items that are intended for decoration, diversional or recreational purposes, and
- Services or items that are covered under other waiver services such as environmental modifications, electronic home-based services, or assistive technology.

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Service Limitations and Service Units

The total cost of transition services must not exceed \$5,000, per individual lifetime limit. Coverage is one-time regardless of the amount expended up to \$5,000. Coverage of transition services is available for individuals who have resided in a qualified long-term service and supports setting for at least 90 consecutive days.

Transition services are not available to individuals exiting an acute care hospital. Transition Services may be authorized for a maximum of nine (9) months by the DMAS service authorization contractor prior to providing services. The funds are not available to the individual after the conclusion of the nine (9) month authorization period of time. Transition services may be requested up to two months prior to discharge. Authorization must be obtained within 30 days of discharge from the qualifying facility. If not requested within that time frame, the individual will not be considered for transition services.

If transition services authorization is obtained but transition services are not used, the Support Coordinator must submit a cancellation request to the DMAS contractor.

The Support Coordinator must ensure that the requested items are reasonable, necessary, documented in the person-centered ISP, meet the service criteria, and do not exceed the lifetime \$5,000 maximum limit. Upon transition, individuals must live in a home where the individual is responsible for his or her own expenses. This may include:

- A home owned or leased by the individual or a family member: The individual or the family member owns or leases the home. In this situation, the individual must retain equal legal rights under the lease or as the owner,
- An apartment with an individual lease: This type of residence must have living, sleeping, bathing and cooking areas over which the individual or the family have domain and control. If the apartment does not have these areas or the individual does not have control over their use, the apartment would not be considered a qualified residence. The unit must have lockable entrance and exit doors, not just locking doors into the building. To meet the requirement for a qualified residence, the individual (or family representative) must sign a lease for an apartment. Apartments can be fair-market (unsubsidized), affordable and subsidized, senior living complexes and/or senior high-rise apartment buildings (to name a few types). The lease cannot require the individual to receive services from a specific company or require him/her to notify the landlord if he/she is absent for a period of time,
- A community-based residential setting in which no more than four unrelated individuals reside. This may include a small group home, a sponsored residential home, or an apartment with a shared living arrangement with roommates. If a residence is licensed,

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transition service funds cannot be used to purchase any item that is required to be provided by the licensor.

Individuals receiving DD waiver services must receive support from the local community services board (CSB) and/or the support coordinator to facilitate the purchase of necessary items. These agencies/providers will then submit claims to Medicaid's payment system for reimbursement for transition services.

Service Documentation Requirements

Any and all documentation related to transition services in the individual's support coordination record including:

- Documentation of the need for the requested goods and/or services in the person-centered ISP, including the discussion of need with the individual or family member/caregiver, as appropriate,
- Documentation of the individual's or family member/caregiver's, as appropriate, choice of services or goods to be purchased,
- Documentation of the individual's or family member/caregiver's, as appropriate, choice of vendor, if applicable,
- Documentation of the reasonableness of the expense (consideration should be given to ways to provide the items or service in the least expensive, most cost effective manner as well as durability of the items and maintenance requirements),
- Documentation of the date services are rendered and the amount of services and supplies,
- Any other relevant information regarding the purchase,
- Signature of the individual or family member/caregiver, as appropriate, indicating receipt of the item or service (signature must be placed on the front of the store/vendor receipt),
- Documentation of the individual's or family member/caregiver's, as appropriate, satisfaction regarding completion of the service,
- As appropriate, documentation that the individual receiving transition service has received instructions regarding any warranty, repairs, complaints, and servicing that may be needed, and

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- Retention in the record of a receipt for the purchased services and/or goods which documents payment of the fee.

Transition services purchases must match the items that are listed on the Transition Services authorization request. The ISP, housing needs assessment worksheet and transition services worksheet are utilized as documentation to assure eligibility criteria is met.

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	Corresponding Regulation(s)	BI	FIS	CL
Crisis Support Options				
Center-Based Crisis Supports	12VAC30-122	✓	✓	✓
Community-Based Crisis Supports	12VAC30-122-290	✓	✓	✓
Crisis Support Services	12VAC30-350	✓	✓	✓

Center-Based Crisis Services

Service Definition/Description

Center-based crisis support service means planned crisis prevention and emergency crisis stabilization services in a crisis therapeutic home through planned and emergency admissions. This service is designed for individuals who will need ongoing crisis supports. Planned admissions are provided to individuals receiving crisis services who need temporary, therapeutic interventions outside of their home setting to maintain stability. Emergency admissions are 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.

Criteria/Allowable Activities

Center-based crisis support services are available to individuals enrolled in the FIS, CL, and BI waivers.

Center-based crisis support services are designed for an individual who:

- Has a history of – or is experiencing at least one of the following:
 - Psychiatric hospitalization;
 - Incarceration;
 - Residential or day placement that was terminated; or
 - Behavior that has significantly jeopardized placement.
- Meet at least one of the following:
 - Is currently experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
 - Is currently experiencing an increase in emotional distress;
 - Currently needs continuous intervention to maintain stability; or
 - Is causing harm to himself or others.
- Also be:
 - At risk of psychiatric hospitalization;
 - At risk of emergency ICF/IID placement;

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- At immediate risk of loss of community service due to severe situational reaction; or
 - Actually causing harm to himself or others.
- Allowable activities include as appropriate for the individual as documented in the plan for supports:
 - A variety of types of face-to-face assessments (e.g., psychiatric, neuropsychiatric, psychological, behavioral) and stabilization techniques;
 - Medication management and monitoring;
 - Behavior assessment and positive behavior support;
 - Intensive care coordination with other agencies or providers to maintain the individual's community placement;
 - Training for family members/caregivers and providers in positive behavior supports;
 - Skill building related to the behavior creating the crisis such as self-care or ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance; and
 - Supervising the individual in crisis to ensure his safety and that of other persons in the environment.

Center-based crisis support services may only be authorized following a documented face-to-face assessment conducted by a qualified developmental disabilities professional (QDDP) or qualified mental health professional (QMHP).

Center-based crisis support services may not be used for continuous long-term care. Room and board are not components of this service. Medicaid reimbursement is available only for allowable activities that are authorized and provided according to an approved Plan for Supports, when a qualified provider is providing the services.

The center-based crisis support plan for supports may be developed (or revised, if requesting an extension) and submitted to the support coordinator to request service authorization up to 72 business hours of the requested start date for authorization. Under certain circumstances, the request for authorization would fall outside the 72 hour window. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours.

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Service Limitations

Center-based crisis support service is limited to six months per ISP year and will be authorized in increments of up to a maximum of 30 consecutive days with each authorization.

Center-based crisis supports will be authorized based on the schedule of supports on an individualized basis based on the person's needs, but not for more than 24 hours per day.

Center-based crisis support service may not be provided during the occurrence of the following waiver services and must not be billed concurrently (i.e., same dates and times):

- Group home residential service;
- Sponsored residential service;
- Supported living residential service;
- Respite service;
- In-home support services; or
- Personal assistance services.

Center-based crisis support service is available through the waiver only when it is not available through the State Plan.

Service Units

The service unit is an hour.

Service Documentation Requirements

Providers must include in each individual's record:

Providers must include signed and dated documentation of the following in each individual's record:

- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable terms;
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
 - A timetable for the accomplishment of the individual's desired outcomes and support activities;

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- The estimated duration of the individual's needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations and the requirements of the Home and Community-based Services settings regulations (as found in 42 CFR 441.301).
- Supporting documentation that has been developed (or revised, in the case of a request for an extension) and submitted to the support coordinator for authorization within 72 hours of the face-to-face assessment or reassessment.
 - Written documentation in the form of unique, person-centered progress notes or data collected in a supports checklist, as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
 - An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.
 - Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
 - Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
 - Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation will be subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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COMMUNITY-BASED CRISIS SUPPORT SERVICE

Service Definition/Description

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

Criteria and allowable activities

Community-based crisis support service is available to individuals enrolled in the FIS, CL, and BI waivers.

Community-based crisis support service provides ongoing supports to the individual who may have:

- A history of multiple psychiatric hospitalizations, frequent medication changes, or setting changes; or
- A history of requiring enhanced staffing due to the individual's mental health or behavioral issues.

Community-based crisis support service are designed for people who have a history of – or are experiencing at least one of the following:

- Previous psychiatric hospitalization;
- Previous incarceration;
- Residential or day placement that was terminated; or
- Behavior that has significantly jeopardized placement.

In addition, the individual must meet at least one of the following:

- Is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
- Is experiencing an increase in extreme emotional distress;
- Needs continuous intervention to maintain stability; or
- Is actually causing harm to himself or others.

The individual must also be:

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- At risk of psychiatric hospitalization;
- At risk of emergency ICF/IID placement;
- At immediate threat of loss of community service due to a severe situational reaction; or
- Actually causing harm to himself or others.

Community-based crisis support service allowable activities may be provided in either the individual's home or in community settings, or both. Crisis staff should work directly with the individual and with his current support provider or his family/caregiver, or both. This service includes supports during the provision of any other waiver service and may be billed concurrently (i.e., same dates and times).

This service is provided using, for example, coaching, teaching, modeling, role-playing, problem solving, or direct assistance. Allowable activities include, as may be appropriate for the individual as documented in his plan for supports:

- Psychiatric, neuropsychiatric psychological, and behavioral assessments and stabilization Techniques;
- Medication management and monitoring;
- Behavior assessment and positive behavior support;
- Intensive care coordination with agencies or providers to maintain the individual's community placement;
- Family/caregiver training in positive behavioral supports to maintain the individual in the community;
- Skill building related to the behavior creating the crisis such as self-care or ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance; and
- Supervision to ensure the individual's safety and the safety of others in the environment.

Community-based crisis support services may only be authorized following a documented face-to-face assessment conducted by a qualified developmental disabilities professional (QDDP) or qualified mental health professional (QMHP).

Medicaid reimbursement is available only for allowable activities that are authorized and provided according to an approved Plan for Supports, when a qualified provider is providing the services.

- The community-based crisis support plan for supports may be developed (or revised, if requesting an extension) and submitted to the support coordinator to request service

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authorization up to 72 business hours of the requested start date for authorization. Under certain circumstances, the request for authorization would fall outside the 72 hour window. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours.

Service limitations

This service is only available through a waiver only when it is not available through the State Plan.

Service units

The unit of service for community-based crisis support service is an hour. The service 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 1,080 hours. Requests for additional community-based crisis support service in excess of the 1,080-hour annual limit will be considered if justification of individual need is provided.

Service documentation and requirements

Providers must include signed and dated documentation of the following in each individual's record:

- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building, as needed, and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and

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- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.
- Supporting documentation that has been developed (or revised, in the case of a request for an extension) and submitted to the support coordinator for authorization within 72 hours of the face-to-face assessment or reassessment.
- Written documentation in the form of unique, person-centered progress notes or data collected in a supports checklist, as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.
- Documentation to support units of service delivered, and the documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Documentation must include all correspondence and contacts related to the individual.
- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting contemporaneous documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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CRISIS SUPPORT SERVICE

Service definition/description

Crisis support service means intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention, and crisis stabilization for an individual who is experiencing an episodic behavioral or psychiatric event in the community that has the potential to jeopardize the current community living situation. This service is designed to prevent the individual from experiencing an episodic crisis that 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 is also designed to prevent escalation of a crisis, maintain safety, stabilize the individual, and strengthen the current living situation so that the individual can be supported in the community beyond the crisis period.

Crisis support service is designed for individuals experiencing circumstances such as:

- Marked reduction in psychiatric, adaptive, or behavioral functioning;
- An increase in emotional distress;
- Needing continuous intervention to maintain stability; or
- Causing harm to themselves or others.

Criteria and allowable activities

Crisis support service is available to individuals enrolled in the FIS, CL, and BI waivers. Crisis support service may include as appropriate and necessary the following components:

- Crisis prevention services
This component provides:
 - 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. Training for family/caregivers to avert further crises and to maintain the individual's typical routine to the maximum extent possible.
 - Support for the family and individual through team meetings, revising the behavior plan or guidelines, and other activities as changes to the behavior support plan are implemented and residual concerns from the crisis situation are addressed.

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- Crisis intervention services
This short-term service component provides:
 - Supports during a crisis to prevent further escalation of the situation and to maintain the immediate personal safety of those involved.
 - A 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.
 - Staff modeling verbal de-escalation techniques including active listening, reflective listening, validation, and suggestions for immediate changes to the situation.
- Crisis stabilization
This service component enables:
 - Gaining a full understanding of the factors that contributed to the crisis once the immediate threat has resolved and there is no longer an immediate threat to the health and safety of the individual or others.
 - 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.
 - The development of new plans that may include environmental modifications, interventions to enhance communication skills, or changes to the individual's daily routine or structure.
 - Family/caregivers and other persons significant to the individual to receive training from staff in techniques and interventions to avert future crises.

Crisis support services may only be authorized following a documented face-to-face assessment conducted by a qualified developmental disabilities professional (QDDP) or qualified mental health professional (QMHP).

Medicaid reimbursement is available only for allowable activities that are authorized and provided according to an approved Plan for Supports, when a qualified provider is providing the services.

- The crisis support service plan for supports may be developed (or revised, if requesting an extension) and submitted to the support coordinator to request service authorization up to 72 business hours of the requested start date for authorization. Under certain circumstances, the request for authorization would fall outside the 72 hour window. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours.

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Service limitations

This service is only available through a waiver when it is not available through the State Plan.

Service units

- Crisis prevention
 - The unit of the service is one hour and billing may occur up to 24 hours per day if 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 (i.e., same dates and times).
- Crisis intervention
 - The unit of the service is one hour and billing may occur up to 24 hours per day if 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 (i.e., same dates and times).
- Crisis stabilization
 - The unit of the service is one hour and billing may occur up to 24 hours per day if 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 (i.e., same dates and times).

Service documentation and requirements

Providers must include signed and dated documentation of the following in each individual's record:

- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building as appropriate, and that are designed to assist in achieving the individual's desired outcomes;

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- The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.
- Supporting documentation that has been developed (or revised, in the case of a request for an extension) and submitted to the support coordinator for authorization within 72 hours of the face-to-face assessment or reassessment.
 - Written documentation in the form of unique, person-centered progress notes or data collected in supports checklist, as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
 - An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.
 - Documentation to support units of service delivered, and the documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Documentation must include all correspondence and contacts related to the individual.
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

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- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting contemporaneous documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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	CORRESPONDING REGULATION(S)	BI	FIS	CL
EMPLOYMENT & DAY OPTIONS				
Benefits Planning Services	12VAC30-122-280	✓	✓	✓
Community Coaching Services	12VAC30-122-310	✓	✓	✓
Community Engagement Services	12VAC30-122-320	✓	✓	✓
Employment & Community Transportation	12VAC30-122-400	✓	✓	✓
Group Day Services	12VAC30-122-380	✓	✓	✓
Group & Individual Supported Employment	12VAC30-122-400	✓	✓	✓
Workplace Assistance Services	12VAC30-122-570		✓	✓

BENEFITS PLANNING

Service Definition/Description

Benefits planning is an individualized analysis and consultation service. This service assists recipients of a DD waiver and social security (SSI, SSDI, SSI/SSDI) to understand their personal benefits and explore their options regarding working, how to begin employment, and the impact employment will have on their state and federal benefits. This service includes education and analysis about current benefits' status and implementation and management of state and federal work incentives as appropriate. Benefits planning involves the development of written resource materials which aid individuals and their families/legal representatives in understanding current and future rewards that come from working, thereby reducing uncertainties associated with losing necessary supports and benefits if they choose to work or stay on the job. This service facilitates individuals in making informed choices concerning the initiation of work. Furthermore, it provides information and education to individuals currently employed in making successful transition to financial independence.

Criteria/Allowable Activities

Each of the allowable activities is available contingent on the individual meeting criteria for receipt of the service activity. Receipt of this service must not be tied to the receipt of any other covered waiver or Medicaid service. Benefits planning is authorized on a calendar year basis. This service may only be authorized one time per allowable activity per individual per calendar year. However, a service may be reauthorized within a calendar year if the individual's situation has changed in terms of disability conditions, benefit type, or employment status.

Allowable activities include the following, which may be appropriate for the individual as documented in his plan for supports:

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- Pre-employment Benefits Review which may include:
 - Benefits Planning Query (BPQY from Social Security Administration (SSA). Description: A BPQY provides information about an individual's disability cash benefits, health insurance, scheduled continuing disability reviews, representative payee, and work history, as stored in SSA's electronic records. The BPQY is an important planning tool for the individual or other person who may be developing customized services for an individual who expresses interest in employment or remaining on the job.
 - Pre-employment Benefits Summary and Analysis (BS&A). Description: Work with and on behalf of the individual to develop a benefits and net income analysis report with both a current scenario and at least two other potential scenarios involving Social Security work incentives.
 - Employment Change Benefits Summary and Analysis. Description: Work with and on behalf of the individual when he/she experiences a change in employment status to develop a benefits and net income analysis report with both a current scenario and at least two other potential scenarios involving Social Security work incentives.
- Work Incentives Development or Revisions (PASS, IRWE, BWE, IDA): Work with the individual and family/legal representative to develop:
 - Plan to Achieve Self-Support (PASS):
 - Part 1 description: In collaboration with the individual and support system, develop a Plan to Achieve Self-Support (PASS) and ensure submission to the SSA.
 - Part 2 description: Ensure the approval of the PASS plan from the SSA PASS Cadre through modifications or other appropriate services.
 - Impairment Related Work Expenses (IRWE). Description: IRWEs reduce the amount of income that Social Security counts against an individual's benefits by deducting the expense from their total countable wages. In order to qualify for the IRWE, the expense must be related to the individual's disability, work, and be an expense without which he cannot work. This service involves working with the individual to develop and submit appropriate forms and supporting documents to SSA, to successfully obtain the IRWE work incentive.
 - Blind Work Expenses (BWE). Description: Work with and on behalf of an individual confirmed to be blind to develop and submit appropriate forms and

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supporting documents to SSA, to successfully obtain the BWE work incentive. Given these circumstances, SSI will not count any earned income when the primary diagnosis is blindness and the expense is reasonably attributed to earning the income, i.e., guide dog, transportation to and from work, etc.

- Individual Development Accounts (IDA). Description: Work with and on behalf of the individual to develop matched asset building savings accounts to assist him/her in saving towards the purchase of a lifelong asset such as a home, education, or to start a business.
- Student Earned Income Exclusion (SEIE). Description: Work with and on behalf of the individual to develop and submit appropriate documents to SSA to receive benefits under the SEIE work incentive. SEIE allows individuals under the age of 22 who regularly attend school or are involved in a vocational education program to exclude earned income up to a certain amount per a month.
- Medicaid While Working – Section 1619(b). Description: Work with and on behalf of the individual to develop and submit an appropriate letter and supporting documents to SSA, local Virginia Department of Social Services (VDSS – Medicaid Eligibility Worker, and Medicaid to receive benefits under 1619(b), which provides the continuation of Medicaid when a beneficiary loses his SSI due to earnings above the SSI threshold.
- Medicaid Works (Virginia’s Medicaid Buy-In Program). Description: Work with and on behalf of the individual who is currently eligible for and/or receiving Medicaid to complete and submit the MEDICAID WORKS agreement and supporting documents to the local VDSS, to enroll in the Medicaid Buy-In program (may include Medicaid application or updating the resource section of the Medicaid application). This enables workers with disabilities the opportunity to earn higher income and retain more in savings or resources than is typically allowed by Medicaid. For individuals receiving the DD waiver, DMAS DD staff notify either DBHDS and/or the DD waiver individual’s CSB/Support Coordinator of the requirement to hold the DD waiver slot **for up to a 180-day grace period**.
- Work Incentive Revisions. Description: Work with and on behalf of the individual to revise one of the work incentives plans above as determined necessary by a significant change in status.
- Resolution of SSA benefits issues (e.g., Overpayments, Subsidies, Student Earned Income Exclusion, Medicaid While Working)
 - Overpayments. Description: Work with and on behalf of the individual to address Social Security overpayments that arise.

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- Subsidies. Description: Work with and on behalf of the individual to develop and submit appropriate documents to SSA to receive the subsidy work incentive.
- Work Activity Reports. Description: Assist the individual family/legal representative in filling out and returning forms to SSA.
- Other Services
 - ABLEnow. Description: Work with and on behalf of the individual and family, if applicable, to open an ABLEnow account to assist the individual to pay for various expenses related to maintaining health, independence and quality of life.
 - Financial Health Assessment. Description: The Financial Health Assessment (FHA) is a tool used to gauge an individual's understanding of his current financial situation.

Service Limitations

Providers may not bill for waiver Benefits Planning services while the eligible individual has an open employment services case with the Department for Aging and Rehabilitative Services (DARS) and is eligible for the same service through DARS.

The annual plan limit for Benefits Planning services is \$3,000. No unspent funds from one plan year may be accumulated and carried over to subsequent plan years. The table below denotes allowable units per service within Benefits Planning.

Plan for Achieving Self-Support-Part 1	7.0 hours
Plan for Achieving Self Support-Part 2	12.5 hours
Impairment Related Work Expense	9.0 hours
Blind Work Expense	9.0 hours
1619(b) Medicaid	4.5 hours
Student Earned Income Exclusion	9.0 hours
Subsidy	9.0 hours
Work Activity Reports:	6.0 hours
Medicaid Works	5.5 hours
Overpayment	3.5 hours
Benefits Planning Query	1.0 hours
Pre-Employment BSA	7.0 hours
WorkWORLD Summary and Analysis	7.0 hours
Individual Development Accounts	7.0 hours
Section 301/Able Now	4.5 hours
Financial Health Assessment	3.5 hours
WI Revisions	7.0 hours

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The delivery of this service requires a face to face contact with the individual to determine his/her needs and review the product that was developed; however, the actual development of the product/report may be done without the individual present.

Service Documentation Requirements

- Providers must include in each individual's record:
 - The provider's plan for supports that includes the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that reflect the service being provided and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered, 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 responsible for overall coordination and integration of the services specified in the plan for supports.
- Documentation in the form of a note which confirms the amount of time spent with the individual, as well as the amount of time dedicated to completion of the work surrounding the benefits planning activity/document.
- Documentation to support units of service delivered, and the documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual.
- All completed documents (the actual product or report that is the outcome of the service) as they relate to Benefits Planning activities. If the individual or the family has withdrawn from the process prior to the document's completion, all portions that were completed should be documented along with a note that describes the circumstances during each session.
 - A written review supported by documentation in the individual's record must be submitted to the support coordinator quarterly, during any quarters in which the service was provided, with the plan for supports, signed by the individual or family member/caregiver, as appropriate, if the plan for supports is modified.
 - Each quarterly person-centered review must contain the following elements:

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- A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
- Information about any newly identified safety risks;
- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the support coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator.

- Documentation that all available and appropriate funding sources (including those offered by Virginia Medicaid State Plan, the DARS, and the Department of Education (DOE) have been explored and exhausted.
- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims that are not supported by appropriate documentation are subject to recovery by DMAS as a result of utilization reviews and audits.

COMMUNITY COACHING

Service Definition/Description

Community coaching is a service 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 identified in their person-centered ISP that prevent individuals from participating in activities of community engagement. In addition to skill building, this service includes routine and safety supports.

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The service is individualized for each person. Each person's journey towards community integration is different and may involve multiple steps towards building relationships and natural supports. These steps should progressively build on each other with the end result being the development of relationships and natural supports. Documentation should capture the progress and the individual's response to each step.

Established definitions of “relationships” include the diverse ways individuals associate and connect. One aspect of community integration is having a variety of relationships of varied intensities and depths. These relationships enable individuals to navigate their community more independently and with natural supports.

Relationships should be considered in context of the setting and do not require individuals to connect with the same person at each location but instead to engage with others in the settings and reduce reliance on staff in community settings and increase autonomy and independence. Examples of this include (but are not limited to)

- Requesting location of a restroom from an employee at the location instead of staff,
- Understanding non-verbal cues from others about when to engage,
- When to continue to engage, and when to end engagement.

Additionally, establishing relationships for individuals with non-verbal communication methods include helping to translate non-verbal responses for community members, modeling for community members how to engage with individuals with non-verbal communication skills, and encouraging that direct interaction.

Criteria/Allowable Activities

Community coaching services are available to individuals enrolled in the FIS, CL and BI waivers.

Skill building must be a component of this service unless the individual has a documented progressive condition, in which case community coaching services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Each individual’s Plan for Supports should minimally have one skill building activity around engagement with community members and one skill building activity around addressing the documented barrier to community engagement.

In addition to being designed to address barriers to engagement, Community Coaching is also intended to be time limited per barrier or steps to address barrier. If progress is not being made, the provider should revisit the barrier and current methodology for addressing this. The meaning of “time limited” is dependent on the individual and his/her support needs. For some individuals time limited may mean six months while for others there are multiple barriers that require specific and targeted intervention. “Barriers to engagement” include a variety of issues and concerns based on the individual’s needs. Some examples of barriers to engagement include behavioral support

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needs, mobility support needs that cannot be addressed as part of a group, and medical support needs such as for individuals with epilepsy where the provider must assess environments to ensure they do not trigger seizure activity.

While each intervention may be time limited, the service itself may be approved for extended periods of time.

Community coaching activities and supports must be contained in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences.

- Allowable activities include:
- One-on-one skill-building and coaching to facilitate participation in community activities and opportunities such as:
 - Activities and public events in the community;
 - Community education, activities, and events, and;
 - Use of public transportation, if available and accessible.
- Skill building and support in positive behavior, relationship building and social skills;
- Routine supports with the individual's self-management, eating and personal care needs in the community. It is permissible for individuals to return to a central location to care for plan-specific hygiene issues;
- Assuring the individual's safety through one to one supervision in a variety of community settings;
- Monitoring the individual's health and physical condition and providing supports with medication and other medical needs; and
- Providing routine supports and safety supports with transportation to and from community locations and resources.

Service Limitations

This service must be provided to one individual at a time per activity with at least one staff person and not as part of a group.

Other than time for planning community activities or if individuals need to return to a central location for plan-specific hygiene issues, this service must be delivered in the community and may

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not take place in a licensed residential or day setting or the individual's residence. These activities may not exceed ten percent of the total number of authorized hours per month.

Community coaching should not be used to supplant the expectation of community involvement of other providers or services (e.g., residential), nor should it limit the number and type of staff/others with whom the individual can participate in community activities. Community coaching starts for reimbursement purposes when the individual is en-route to his identified activity. Transportation time should not exceed the value of the activity (for example the provider would not drive one hour to a store when another location of that same store is 10 miles away). This does not negate that there are special events which require longer transportation time.

The community coaching service, alone or in combination with the community engagement service, group day service, workplace assistance service, or supported employment service must not exceed 66 hours per week.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their service authorization request for the combination of these services. The provider may request up to 10 additional hours of community coaching per week that will allow the individual to choose additional community coaching outings. These hours should be proportional to the requested amount of community coaching.

In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based

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on information in the Personal Profile, Essential Information, the Virginia SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Units

The unit of service is one hour.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms,
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes,
 - The services to be rendered and the schedule of 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 needs for services,
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

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- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
 - An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe;
 - Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made; and
 - In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
- The plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

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- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.
- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
 - Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
 - For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
 - Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

COMMUNITY ENGAGEMENT

Service Definition/Description

Community engagement services support and foster an individual's 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 participating in community education or training and volunteer activities.

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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 relationships and natural supports.

The service is individualized for each person. Each person's journey towards community integration is different and may involve multiple steps towards building relationships and natural supports. These steps should progressively build on each other and the end result would be the development of relationships and natural supports. Documentation should capture the progress and the individual's response to each step.

Established definitions of “relationships” include the diverse ways individuals associate and connect. One aspect of community integration is having a variety of relationships of varied intensities and depths. These relationships enable individuals to navigate their community more independently and with natural supports.

Relationships should be considered in context of the setting and do not require individuals to connect with the same person at each location but instead to engage with others in the settings and reduce reliance on staff in community settings and increase autonomy and independence. Examples of this include (but are not limited to):

- Requesting location of a restroom from an employee at the location instead of staff,
- Understanding non-verbal cues from others about when to engage,
- When to continue to engage, and when to end engagement.

Additionally, establishing relationships for individuals with non-verbal communication methods include helping to translate non-verbal responses for community members, modeling for community members how to engage with individuals with non-verbal communication skills, and encouraging that direct interaction.

Criteria/Allowable Activities

Community engagement is available to individuals enrolled in the FIS, CL, and BI waivers. This is not a center-based service. Community engagement activities and supports must be contained in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences. This service must be provided in the least restrictive and most integrated community settings possible according to the individual's Plan for Supports and individual choice. In addition, community engagement service is available for individuals who can benefit from the supported employment service, but who need community engagement service as an appropriate alternative or in addition to the supported employment service.

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Skill building must be a component of this service unless the individual has a documented progressive condition, in which case community engagement services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills.

Allowable activities may include, as appropriate for the individual as documented in his/her plan for supports:

- Skill building, education, support, and monitoring that assists the individual with the acquisition and retention of skills in the following areas while in the community:
 - Participation in activities and public events in the community;
 - Participation in community educational activities and events;
 - Development of interests and activities that encourage therapeutic use of leisure time (where therapeutic use is defined as use that promotes social, emotional, physical, and/or personal wellbeing development);
 - Participation in volunteer experiences, including those that might lead to determining employment interests;
 - Maintenance of contact with family and friends (the individual must have a documented need for skill development to maintain healthy relationships with identified friends or family); and
 - Development of independence in activities of daily living.
- 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.):
 - Development of self-advocacy skills (e.g., appropriately speaking up for oneself with one's family, friends, potential employers, community members, or policy makers. This could also include effective public speaking.);
 - Exercise of civil rights (defined as the rights of individuals to receive equal treatment and to be free from unfair treatment or "discrimination" in a number of settings, including education, employment, housing, and includes activities such voting, public speaking, visiting political officials, key decision makers. This is not an inclusive list of possibilities.);

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- Acquisition of skills that promote the ability to exercise self-control and responsibility over services and supports received or needed;
- Acquisition of skills that enable the individual to become more independent, integrated, or productive in the community;
- Development of communication skills and abilities;
- Furtherance of spiritual practices as desired by the individual;
- Participation in cultural activities as desired by the individual;
- Development of skills that enhance career planning goals in the community, where “career planning” includes gaining information to make an informed decision about whether a person wants to work, as well as exploring types of work opportunities and gaining information regarding the person’s employment interests and preferences;
- Development of independent living skills;
- Promotion of health and wellness, including administration of medication;
- Development of orientation to the community and mobility in the community;
- Access to and utilization of public transportation so as to develop the ability to achieve the desired destination;
- Interaction with volunteers from the community in program activities.
- Providing routine supports and safety supports with transportation to and from community locations and resources.

Service Limitations

Community engagement may include planning community activities with the individual or individuals present in a group of no more than three individuals. Other than time for planning community activities or if individuals need to return to a central location to care for plan-specific hygiene issues, this service must be delivered in the community and may not take place in a licensed residential or day setting or the individual’s residence. These activities may not exceed 10 percent of the total number of authorized hours per month.

Community engagement:

- Should not be used to supplant the expectation of community involvement of other providers or services (e.g., residential);

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- Should not limit the number and type of staff/others with whom the individual can participate in community activities; and
- May be provided in groups no larger than three individuals with a minimum of one DSP per activity per provider.

The provider may transport six individuals to two staff to the community but individuals must participate in separate and distinct activities according to the maximum group size. Community engagement begins when the individuals are en route to their identified activity. Transportation time should not exceed the value of the activity (for example the provider would not drive one hour to a store when another location of that same store is 10 miles away.) However, it does not negate that there are special events in which it would be beneficial for the individual to participate that require longer transportation time.

Community engagement service alone or in combination with the group day service, community coaching service, workplace assistance service, or supported employment service must not exceed 66 hours per week.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their service authorization request for the combination of these services. The provider may request up to 10 additional hours of community engagement per week that will allow the individual to choose additional community outings. These hours should be proportional to the requested amount of community engagement.

In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based

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on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Units

The unit of service is one hour.

Community engagement is a tiered service for reimbursement purposes. Providers will only be reimbursed for the tier to which the individual has been assigned based on the individual's assessed and documented needs.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities; and
 - A timetable for the accomplishment of the individual's desired outcomes and support activities.
- The estimated duration of the individual's needs for services;
- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;

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- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note;
- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe;
- Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made;
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted,
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

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- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

EMPLOYMENT AND COMMUNITY TRANSPORTATION (ECT)

Service Definition/Description

This service is offered in order to enable individuals to gain access to their place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the ISP and when no other means of access is available. The goal of this service is to promote the individual's independence and participation in the life of his/her community. Use of this service is related to the individual's desired outcomes as stated in the ISP. This service is offered in addition to Medicaid funded medical transportation and

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transportation services covered under the State plan to and from waiver-funded services, and does not replace them.

Criteria/Allowable Activities

The service may include transportation in a private vehicle by a person such as a co-worker or other community member or the purchase of tickets for public transportation such as bus or subway. In either case, an administering agency must coordinate and bill DMAS.

Up to three individuals may be transported in a single, private vehicle per trip.

The administering agency will ensure that pertinent information about the individual is relayed to the driver of the private vehicle. This may include emergency contact, known medical or behavioral challenges that might impact the driver, other passengers, or the individual while traveling.

The individual and the ECT administering agency must develop an ECT Trip Plan (DMAS – P258) and submit the Trip Plan to the support coordinator. A printout from MapQuest or Google Maps or similar printout for each trip must accompany the Trip Plan to verify the mileage from the point of origin to the destination. Both of these will be submitted for service authorization. Service authorization staff must verify that:

- The trips are related to an ISP goal (e.g., the trip purpose and frequency is congruent with the ISP goal);
- The trips are for non-medical purposes;
- The trip distance estimates are accurate; and
- Whether the individual receives other direct support services from the ECT provider (e.g., employment services, residential services, personal assistance services, etc.). If so, staff will confirm that the proposed private community driver is not a member of the ECT administering provider's staff.

When ECT providers coordinate transportation using a private vehicle with a community driver, service authorization staff will authorize each “one-way trip” and the estimated number of trips per month. A one-way trip begins at the eligible rider's point of origin and ends when the eligible rider reaches his/her destination.

Service Limitations

This service may not be authorized or reimbursed for individuals who can access transportation through the State Plan or other waiver services which include a transportation component. The

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individual or legal guardian must attest that he/she does not have sufficient personal financial resources (e.g., through wages) to cover the cost of the transportation himself/herself.

The purchase of tickets for public transportation and dissemination to the individual is coordinated by the administering agency.

An administering agency delivering other waiver services to an individual may not utilize staff to provide ECT and may only bill ECT if the transportation is not a normally required element of service provision (i.e., an allowable activity for the other service(s) the provider delivers to that individual).

The administering agency may not bill for a rider who is not ECT-approved (e.g., a passenger who is the driver's family member, friend, etc.).

Service Units

Private transportation is reimbursed according to a "trip" (which is reimbursed for the round-trip) and the number of individuals being transported to the location (maximum of three). There are three trip rates depending on the **one-way** distance traveled:

- Under 10 miles
- Between 10 – 20 miles
- Over 20 miles.

The trip rate is determined based upon distance traveled, the number of ECT-approved riders, and the rate schedule for the geographic location where the transportation takes place. An administrative cost reimbursement is built into each trip rate.

When a private driver is transporting more than one individual to a single destination, the trip rate for all individuals is the same and is determined by the distance between the first individual picked up and the final destination. For example, the driver picks up individual A and then individual B to take them both to the same workplace. Individual A lives 15 miles from their place of employment. Individual B lives 9 miles from that destination. The administering provider may bill the 10 – 20 mile trip rate for both individuals. Included in that rate is reimbursement for the driver's return trip after dropping off the individuals.

When the ECT administering provider arranges access to public transportation by purchasing public transportation fares such as bus or rail tokens, tickets, passes, fare cards, etc., service authorization staff approves the actual fare cost plus the administrative fee.

Service Documentation Requirements

Administering providers must include in each individual's record:

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- A copy of the completed, standard, age-appropriate assessment form, such as the Supports Intensity Scale®.
- The provider's plan for supports in the form of the ECT Trip Plan form.
- Documentation of the trip distance estimate in the form of a MapQuest, Google Maps, or similar printout with point of origin/destination and mileage.
- Documentation to support units of service delivered in the form of a monthly trip log (DMAS-P259) signed by the individual or caregiver/guardian, as appropriate, recording trips taken, that must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual.
- A written review, supported by documentation in the individual's record, must be submitted to the support coordinator quarterly, during any quarters in which the service was provided and if modified, with the plan for supports. This written review must list the dates and destinations of trips taken and a statement about the individual's satisfaction with the service. The quarterly person-centered review is due to the Support Coordinator no later than 10 days following the end of the quarter. For the annual review and every time the Plan for Supports is updated, the revised Plan for Supports will be reviewed with the individual or family/caregiver, as appropriate, and such review must be documented.
- For private drivers:
 - Copies of valid drivers' licenses;
 - Copies of the automobile insurance policies;
 - Copies of driving records;
 - Criminal records attestations and Virginia Sex Offender Registry record checks,
 - The driver is responsible for notifying the agency if there are any changes to previously submitted attestations or significant driving record changes vs. requiring the agency to have to obtain this information each year.
- For public transportation, receipts for purchases of bus tickets or fare cards.
- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.

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GROUP DAY SERVICES

Service Definition/Description

Group day services are those services designed to enable 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. This service is typically offered in a non-residential setting. Group day is a tiered service for reimbursement purposes.

Group Day activities and supports must be detailed in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences.

Criteria/Allowable Activities

Group day services are available to individuals enrolled in the FIS, CL, and BI waivers.

While routine supports may be provided, skill building must 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.

For group day services, an individual must demonstrate the need for skill-building or supports offered primarily in settings other than the individual's own residence that allows an opportunity for being a productive and contributing member of his community. In addition, group day service is available for individuals who can benefit from the supported employment service, but who need group day service as an appropriate alternative or in addition to the supported employment service.

Allowable activities may include, as may be appropriate for the individual as documented in his plan for supports:

- Developing problem-solving abilities, sensory, gross and fine motor control abilities, communication, and personal care skills;
- Developing self, social, and environmental awareness skills;
- Developing skills as needed in:
 - Positive behavior;
 - Using community resources;
 - Community safety and positive peer interactions;
 - Volunteering and participating in educational programs in integrated settings;
 - Forming community connections or relationships.

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- Supporting older adults in participating in meaningful retirement activities in their communities (i.e., clubs and hobbies);
- Skill building and routine supports related to ADLs and IADLs;
- Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;
- Providing safety supports in a variety of community settings;
- Career planning and resume developing based on career goals, personal interests, and community experiences; and
- Providing routine supports and safety supports with transportation to and from community locations and resources.

Group day services should be coordinated with the therapeutic consultation plan and any physical, occupational, or speech/language therapies listed in the Individual Support Plan, as applicable.

Service Limitations

- 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;
- Group day staffing ratios are based on the activity and the individual's needs as set out in the individual's plan for supports. There must be at least one staff to seven individuals;
- Group day should not be used to supplant the expectation of community involvement of other providers or services (e.g., residential);
- Group day should not limit the number and type of staff/others with whom the individual can participate in community activities;
- Service providers will 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.

Group day services cannot be provided in an individual's home or other residential setting without written, prior approval from DBHDS. In this situation, the Plan for Supports must clearly indicate the specific time frame and designate specific day support activities provided in the individual's home or other residential setting. Some examples include:

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- An individual's group day Plan for Supports includes allowable support activities at a residential site (e.g., learning or practicing skills related to grounds maintenance), provided these activities are not routinely performed by residents of that home;
- A new individual, or one with serious emotional/behavioral challenges, requires a temporary "phase-in period," with the expected duration to be clearly indicated on the Plan for Supports, to become accustomed to staff, a schedule and routine, riding in a van or car, etc. Only one unit of group day services provided at the individual's home may be billed; and
- Individuals return from community settings to a residence for lunch. The "lunch location" and amount of time allotted for lunch (including preparation and cleanup) must be specified on the day support Plan for Supports."

In instances where group day services staff are required to ride with the individual from his/her home to 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 must 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.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their service authorization request for the combination of these services. The provider may request between 3-5 hours of additional group day services per week that will allow the individual to choose additional community outings. These hours should be proportional to the requested amount of community engagement.

In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

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60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Units

The service unit is an hour.

Group day services, alone or in combination with community engagement, community coaching, workplace assistance, or supported employment services, must not exceed 66 hours per week.

Group day service is a tiered service for reimbursement purposes. Providers will only be reimbursed for the individual's assigned level and tier.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;

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- The services to be rendered and the schedule of 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 needs for services.
- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations and the requirements of the Home and Community-based Services settings regulations (as found in 42 CFR 441.301).
 - Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
 - An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.
 - Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
 - In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

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- A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
- Information about any newly identified safety risks;
- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;
- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate;

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- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation is subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

SUPPORTED EMPLOYMENT

Service Definition/Description

Group and individual supported employment services consists of ongoing supports provided by a job coach that enables individuals to be employed in an integrated work setting where persons without disabilities are employed 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 by the individual to sustain paid work.

This service is 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. Group and individual supported employment service may be provided in either of the following service models:

Individual Supported Employment (ISE) Service

Individual supported employment (ISE) service involves one-on-one support that enables individuals to work in an integrated setting. The outcome of this service is 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 is limited to actual documented interventions or collateral contacts by the provider as required by the individual receiving waiver services. Reimbursement may not be provided for the supervisory activities rendered as a normal part of the regular business setting nor for the amount of time the individual enrolled in the waiver, is merely in the supported employment situation.

Group supported employment (GSE) service

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 must be provided in a community setting that promotes integration into the workplace and interaction in the workplace between waiver participants and people without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group supported employment settings must comply with the HCBS setting requirements per 42 CFR 441.301

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Criteria/Allowable Activities

Through past experience or assessment information the individual must have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports and that because of the individual's disability, he/she needs ongoing support to perform in a work setting. The individual's assessment and ISP must clearly reflect the individual's need for employment-related skill-building.

This service is designed to support individuals in competitive, integrated positions for whom all options for independence in regards to appropriate job match, reasonable accommodations, and the utilization of natural supports in the workplace have been explored, exhausted and documented. This service is supplementary to individual supported employment in order to maintain stability in the workplace.

Allowable activities for both individual and group supported employment services include the following job development tasks, supports, and training. For DMAS reimbursement to occur, the individual must be present, unless otherwise noted, when these activities occur:

- Vocational or job-related discovery or assessment;
- Person-centered employment planning that results in employment related outcomes;
- 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 limited to ISE only and is not permitted for GSE;
- Negotiation with prospective employers, with or without the individual present;
- On-the-job training in work skills required to perform the job;
- Ongoing evaluation, supervision, and monitoring of the individual's performance on the job, which does not include supervisory activities rendered as a normal part of the business setting;
- Ongoing support necessary to ensure job retention, with or without the individual present;
- Supports to ensure the individual's health and safety during the hours of work;
- Development of work-related skills essential to obtaining and retaining employment, such as the effective use of community resources, break or lunch areas, and transportation

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systems. This may not exceed 25% of the total amount of time the individual is actually being paid to work; and

- 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 must be present with the individual during the provision of transportation in order to be reimbursed.

The ISE service model may also consist of *Customized Employment* (CE). This flexible process is designed to personalize the employment relationship between a job candidate or employee and an employer in a way that meets the needs of both. It is based on identifying the strengths, conditions, and interests of a job candidate or employee beginning with discovery and concluding with post-employment supports.

The essential components of customized employment are:

- Discovery - Gathering information from the job seeker and the CE support team (a group of multiple partners, including the employment specialist who all jointly take some responsibility for the job seeker's needs; however, the job seeker is the ultimate decision-maker) to determine the job seeker's interests, skills, and preferences related to potential employment that guide the development of a customized job.
- Job Search Planning - Using the information learned about an individual job seeker in Discovery to develop a plan toward a meaningful employment, determine a list of potential employers, and conduct an informal analysis of benefits which may result in recommending that the SC seek the service of Benefits Planning.
- Job Development and Negotiation - Working collaboratively with the individual and the employer to negotiate a customized job; the provision of supports; and the terms of employment that will match the individual's interests, skills, conditions necessary for success, and specific contributions, and will fill the unmet needs of an employer.

Service Limitations

Only activities that specifically pertain to the individual will be allowable activities under the supported employment service and DMAS will cover this service only after determining that this service is not available from DARS or the local school system.

Group and individual supported employment service alone or in combination with the community engagement service, community coaching service, workplace assistance service, or group day service must not exceed 66 hours per week.

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GSE must take place in nonresidential settings separate from the individual's home.

For time-limited and service authorized periods (not to exceed 24 hours) ISE may be provided and billed during the same hours as day services or residential services for purposes of discovery under customized employment.

Individual supported employment service can be provided simultaneously with the workplace assistance service to ensure that the workplace assistant is trained and appropriately supervised about supporting an individual through the best practices of individual supported employment. As well, Individual Supported Employment and personal assistance can be provided simultaneously to ensure the individual receives necessary personal care during the work day.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Unit

The unit of service for ISE and GSE is one hour, and the service is limited to 40 hours per week per individual.

Reimbursement for GSE is based on the size of the group.

ISE must be billed according to the DARS fee schedule.

Service Documentation Requirements

- Providers must include signed and dated documentation of the following in each individual's record:
 - A completed copy of the age-appropriate, DBHDS approved SIS®.
 - The provider's plan for supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;

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- Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
- The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
 - It should be noted that employment and employment related activities do not occur on a set schedule and so therefore a schedule for supports will be an estimation of when the supports will occur and may overlap with other services particularly during job development, situational assessments and placement and training. This may also occurring during actual employment where the individual has changing shifts and hours. Documentation from the employment service organization should include a statement around billing for services only when provided regardless of the schedule.
- A timetable for the accomplishment of the individual's desired outcomes and support activities,
- The estimated duration of the individual's need for services,
- The provider staff responsible for overall coordination and integration of the services specified in the plan for supports,
- For GSE, documentation regarding any restrictions on the freedoms of everyday life in accordance with the requirements of 42 CFR 441.301;
- Documentation of the individual's ineligibility for supported employment service through DARS or IDEA, as applicable. If the individual is ineligible to receive service through IDEA, documentation is required only for lack of DARS funding. Acceptable documentation for the lack of DARS or IDEA funding would include a letter from either DARS or the local school system or a record of a telephone call, including name, date, and person contacted, documented either in the individual's file maintained by the support coordinator, on the ISP, or on the supported employment provider's supporting documentation. Unless the individual's circumstances change, for example, the individual is seeking a new job, the original verification may be forwarded into the current record or repeated on the supporting documentation on an annual basis;
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a

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daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note;

- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe;
- Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made; In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented,

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either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation is subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

WORKPLACE ASSISTANCE

Service Definition/Description

Workplace assistance services are supports provided to an individual who has completed job development and completed or nearly completed job placement training (i.e., individual supported employment) but requires more than the typical job coach services, as detailed in the individual supported employment section of this chapter, to maintain stability in his employment. This service is supplementary to individual supported employment service. Workplace assistance service are covered in the Family and Individual Support and Community Living waivers.

Criteria/Allowable Activities

Workplace assistance must not be work skills training that would normally be provided by a job coach, such as supporting the individual in learning the components of the job. Instead the service is designed to help the individual who has learned the basic skills of the job to maintain community employment.

This service is delivered in the individual's natural employment setting, where and when it is needed.

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Allowable activities include:

- Habilitative supports (i.e., skill building) related to non-work skills needed for the individual to maintain employment such as appropriate behavior, health maintenance, time management, or other skills without which the individual's continued employment would be endangered;
- Habilitative supports (i.e., skill building) needed to make and strengthen community connections (e.g., facilitating relationships with co-workers, supervisors, customers or using break or lunch time to access local community supports);
- Routine supports with personal care needs; however, this cannot be the sole use of workplace assistance service; and
- Safety supports needed to ensure the individual's health and safety.

Service Limitations

The unit of service is an hour. Workplace assistance service may be provided during the time that the individual being served is working in the community, up to and including 40 hours a week. There is no annual limit on how long this service may remain authorized.

Workplace assistance service must not be provided simultaneously (i.e., the same dates and times) with work-related personal assistance service. This service must not be provided solely for the purpose of providing assistance with ADLs to the individual when the individual is working.

The service delivery ratio is one staff person to one individual receiving waiver services.

The combination of workplace assistance service, community engagement service, community coaching service, supported employment service, and group day service must not exceed 66 hours per week.

Workplace assistance service can be provided simultaneously with individual supported employment (ISE) service to ensure that the workplace assistant is trained and supervised appropriately in supporting the individual through ISE best practices. The long-term expectation is that, after the job coach fades his/her regular involvement with the individual on the job site (i.e., job coach reduces proximity to the individual, reduces the types of prompts provided, and ultimately reduces the amount of time he/she needs to be physically present to assure the individual is able to do the job), the workplace assistant will remain with the individual. It is expected that the job coach and workplace assistant will continue to have periodic contact regarding the job performance/status of the individual.

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“Fading,” for the purposes of supported employment, is the process of transitioning an individual from external supports, services, and cues to natural supports, services, and cues in the employment environment.

Service Documentation Requirements

- Providers must include signed and dated documentation of the following in each individual's record:
 - A copy of the completed age-appropriate assessment (i.e., Supports Intensity Scale).
 - The provider's plan for supports which includes at a minimum the following:
 - The individual's desired outcomes that describe what is important to and for the individual in observable terms;
 - Support activities and support instructions that are inclusive of skill-building as may be required by the service provided and that are designed to assist in achieving the individual's desired outcomes;
 - 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;
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.
- Documentation in the form of unique, person-centered, written documentation in the form of progress notes or data collected in a supports checklist as appropriate, per the plan for supports. These shall be in each individual's record and detail the individual's responses to supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Such documentation must be provided to DMAS or its designee upon request. Such documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
 - In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support

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coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

- The content of each review must be reviewed/discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter.
 - The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion.
- The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year.
 - For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review shall be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
 - All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
 - Written progress note documentation of contacts made with the individual's family/caregiver, physicians, providers, and all professionals concerning the individual.

Provider documentation must support all claims submitted for DMAS reimbursement. 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.

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	Corresponding Regulation(s)	BI	FI	CL
MEDICAL AND BEHAVIORAL SUPPORT OPTIONS				
Personal Emergency Response Systems (PERS)	12VAC30-122-470	✓	✓	✓
Private Duty Nursing	12VAC30-122-480		✓	✓
Skilled Nursing	12VAC30-122-520		✓	✓
Therapeutic Consultation	12VAC30-122-550	✓	✓	✓

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Service Definition/Description

Personal emergency response system (PERS) service is an electronic device and monitoring service that enables certain individuals to secure help in an emergency. PERS service is 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.

Criteria

PERS service is available to individuals enrolled in the FIS, CL, and BI waivers. PERS service 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. Physician-ordered medication monitoring units may be provided simultaneously with PERS service. These units must be refilled as needed by either a LPN or RN.

PERS service must include 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,
- Determining whether an emergency exists, and
- Notifying an emergency response organization or an emergency responder that the individual needs emergency help.

The agency providing monitoring services must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. The provider is responsible for ensuring that the monitoring agency and the agency's equipment meet the requirements of this section. The monitoring agency must be capable of simultaneously responding to multiple signals for help from multiple individuals' PERS equipment. The monitoring agency's equipment must include the following:

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- A primary receiver and a back-up receiver, which must be independent and interchangeable;
- Back-up information retrieval system;
- A clock printer, which must 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;
- Back-up power supply;
- A separate telephone service;
- A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS service elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures.

PERS service must be capable of being activated by a remote wireless device and must be connected to the individual's telephone system. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must 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.

The emergency response activator must be activated either by breath, by touch, or by some other means and be usable by persons who have visual or hearing impairments or physical disabilities. The emergency response communicator must 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 must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event the unit cannot get its signal accepted at the response center.

Providers must furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider must 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.

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PERS equipment must be properly installed all into the functioning telephone line or cellular system of an individual receiving PERS and all necessary supplies must be furnished to ensure that the system is installed and working properly.

The PERS installation must 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.

The PERS must be installed, tested, and demonstrated to the individual and the individual's family/caregiver, as appropriate, before claims may be submitted for reimbursement to DMAS. The individual, family/caregiver, as appropriate, and responders must be instructed in the use of the PERS.

All installed PERS equipment must be maintained in proper working order. PERS must include back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

All PERS equipment must 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 must be automatically reset by the response center after every activation ensuring that subsequent signals can be transmitted without requiring manual reset by the individual enrolled in the waiver or family/caregiver, as appropriate.

Service units

The one-time purchase unit for installation of the PERS device(s) includes installation, account activation, individual and caregiver instruction, and removal of PERS equipment.

A unit of service for PERS monitoring or PERS monitoring and medication monitoring is the one-month rental price set by DMAS.

The unit of service for LPN or RN refilling of the PERS medication monitoring device is 30 minutes.

Service Limitations

PERS service must not be used as a substitute for providing adequate supervision for the individual enrolled in the waiver.

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Medication monitoring units and the accompanying LPN or RN visits to refill the unit may not be standalone services, but must be provided in tandem with an overall PERS installation and monthly monitoring service.

Incompatible Services

Group home residential
Sponsored residential
Supported living residential

Service documentation and requirements

- The support coordinator must include signed and dated documentation of the following in each individual's record:
 - The appropriate service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of PERS service. A rehabilitation engineer may be involved for PERS service if disability expertise is required that a general contractor may not have. The plan for supports and service authorization must include justification and explanation if a rehabilitation engineer is needed. The service authorization request must be submitted to the state-designated agency or its designee in order for service authorization to occur;
 - Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as durable medical equipment (DME) and supplies and that the item is not available from a DME provider;
 - Documentation of the recommendation for the item by an independent professional consultant (physical therapist, occupational therapist, behavioral consultant, or similarly credentialed professional) and the amount of service that is needed;
 - Documentation of notification by the designated individual or the individual's representative or family/caregiver, as appropriate, of satisfactory installation or receipt of each PERS device.
- The PERS provider must maintain a data record for each individual receiving PERS service that documents all of the following:
 - Delivery date and installation date of the PERS;
 - The signature of the individual or the individual's family/caregiver, as appropriate, verifying receipt of PERS device;

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- Verification by a test that the PERS device is operational, monthly or more frequently as needed;
 - Updated and current individual responder and contact information, as provided by the individual or the individual's support coordinator; and
 - A case log documenting the individual's utilization of the system and contacts and communications with the individual or the individual's family/caregiver, as appropriate, support coordinator/case manager, or responder.
- The PERS provider must also 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.
 - The PERS provider must maintain documentation of any other relevant information regarding the device or modification, as well as instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

PRIVATE DUTY NURSING (PDN)

Service Definition/Description

Private duty nursing (PDN) service means nursing services that are provided by a Registered Nurse (RN) or Licensed Practical Nurses (LPN) and are designed to provide the individual continuous nursing care. PDN services are available to individuals who require more hours per week of nursing care than may be provided under Skilled Nursing in the waivers. This means more than 21 hours per week. PDN services are provided for individuals enrolled in the DD waiver who have serious medical conditions and complex health care needs that have been certified by a physician or nurse practitioner (in accordance with § 54.1-2957.02, which states that, whenever a physician's signature is required, a nurse practitioner's signature must also be accepted) as medically necessary to enable the individual to remain at home or in a community residence rather than in a hospital, nursing facility, ICF/IID, or any other type of institution.

PDN service must be delivered as direct one-to-one person-centered nursing care. PDN must support and not replace existing family or paid caregiver responsibilities.

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PDN services may be provided concurrently with other services such as the services of direct support professionals in residential or day support settings due to the medical nature of the supports provided.

Criteria/Allowable Activities

Individuals enrolled in the Community Living (CL) or Family and Individuals Supports (FIS) waivers may receive PDN.

The individuals who are authorized to receive this service must require specific PDN service as documented in the individual's plan for supports and ordered by a physician or nurse practitioner. This means that the individual must have a documented need and those needs outlined and nursing services ordered by the medical practitioner. This also means that the ISP cannot be implemented effectively unless the nursing services are authorized and provided.

Private Duty Nursing (PDN) services may be provided to the individual in his/her residence or other community setting on a regularly scheduled basis to facilitate the desired health and safety outcomes as outlined in the individual's ISP.

Allowable activities must be ordered and certified as medically necessary by a Virginia-licensed physician or nurse practitioner on the CMS 485 form.

The allowable activities for PDN may include:

- On-going monitoring of an individual's medical status as it relates to the specified medical and nursing needs;
- Administering medications and other medical treatments ordered specifically for the individual's care;
- Assisting with activities of daily living in conjunction with medical treatment and care; and/or
- Training of family members or other caregivers regarding the nursing care of the individual per the plan for supports.

Service Limitations

The medical necessity for PDN services is documented in the individual's ISP. Once it has been determined by a physician or nurse practitioner that medical necessity can no longer be demonstrated, this service must be terminated and the ISP updated to reflect the change in status.

PDN cannot be provided concurrently (i.e., during the same billing unit timeframe) with skilled nursing services, personal assistance services, respite services, or companion services. Individuals receiving PDN services may not be authorized for skilled nursing services except when skilled

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nursing is required for nurse delegation responsibility activities in accordance with 18VAC90-19-280 and are authorized and included in the individual's ISP.

PDN service may not be covered under the waiver if the individual is younger than 21 years of age and is eligible for private duty nursing service covered through Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The Private Duty Nursing service is a one-to-one service. It is not a group service and thus the services of the nurse may be billed for only one individual at a time.

Examples of Allowable Service Delivery and Billing When There Are Multiple Individuals in the Setting:

- 1) Two individuals living in the same residence:
 - Individual A requires 12 hours of PDN per day and Individual B requires 12 hours of PDN per day. Each individual is authorized 12 hours per day of PDN service.
 - The residence schedules two of their nurses 12 hours per day each (i.e., two nursing shifts) to provide the service for both Individual A & B and bills no more than a total of 24 hours per day of PDN for the services delivered by the two nurses.
- 2) Two individuals living in the same residence:
 - Individual A requires 8 hours per day of PDN and Individual B requires 8 hours per day of PDN. Each individual is authorized 8 hours per day of PDN service. Both of their ISPs described PDN service that is to be provided every other 30 minutes throughout the day.
 - The residence schedules one nurse (one nursing shift) 16 hours per day to provide the service for both Individual A & B and bills 16 hours per day of PDN for one nurses scheduled.

Service Units

PDN is rendered and billed in quarter-hour (15-minute) increments.

Service Documentation and Requirements

Private Duty Nursing services providers shall include signed and dated documentation of the following in each individual's record:

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- A completed copy of the age-appropriate DBHDS–approved SIS® assessment form or other approved, developmentally appropriate assessment according to the individual’s age.
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired health outcomes that describe what is important to and for the individual in observable and measurable terms, particularly related to the individual’s diagnoses and relevant medical history;
 - Support activities and support instructions, including nursing tasks and monitoring, that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.
- Documentation identifying who was trained on the nursing service plan, including family members/caregivers. This documentation must indicate the dates and times and the content of the training.
- Documentation that the RN and LPN has the experience or skills necessary to perform the tasks as ordered by the physician or nurse practitioner and included in the plan for supports.
- Documentation of the nursing licenses and qualifications of private duty nursing providers.
- The physician’s or nurse practitioner’s order may be documented on the CMS 485 form or an equivalent form which must include the following:
 - Orders for skilled nursing services that include a specific number of nursing hours per day (i.e., not a range of hours).
- Documentation of the Physician or Nurse Practitioner orders must be completed every six months. This means that the CMS 485 and the individual plan for supports related to PDN services must be updated every six months.

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- Documentation that clearly describes the amount and type of nursing interventions provided, results of interventions/treatments including the specific the dates and times of nursing interventions and appropriate signatures.
- Documentation that affirms that the PDN services are provided as a one-to-one service in accordance with the plan for supports.
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted,
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

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- Written documentation of all contacts with the individual's family/caregiver, physicians, providers, and all professionals regarding the individual.

Provider documentation must clearly reflect the PDN service authorized and provided and support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by the ISP and the provider's documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

SKILLED NURSING SERVICES

Service Definition/Description

Skilled Nursing (SN) service means nursing services that are provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the form of intermittent care, up to, but not to exceed 21 hours per week as detailed in the individual's ISP. In accordance with 12VAC30-122-520, skilled nursing service must be ordered by a physician and be medically necessary. The medical necessity for skilled nursing services must be documented in the individual's ISP. Once the medical necessity can no longer be demonstrated, this service will be terminated. SN services are provided for individuals enrolled in the DD waiver who have serious medical conditions and complex health care needs and have exhausted their home health benefits under the Commonwealth's Medicaid benefit or other benefits available to the individual and who require specific nursing care.

SN services may be provided concurrently with other services such as those delivered by direct support professionals (DSPs) in residential or day support settings due to the medical nature of the supports provided.

Criteria/ Allowable Activities

Individuals enrolled in the Community Living (CL) or Family and Individuals Supports (FIS) waivers may receive SN.

The individuals who are authorized to receive this service must require specific skilled nursing service as documented in the individual's plan for supports and ordered by a physician or nurse practitioner (in accordance with § 54.1-2957.02, which states that, whenever a physician's signature is required, a nurse practitioner's signature must also be accepted). This means that the individual must have a documented need/those needs outlined and nursing services ordered by the medical practitioner. This also means that the ISP cannot be implemented effectively unless the nursing services are authorized and provided.

SN services may be provided to the individual in his residence or other community setting on a regularly scheduled or intermittent basis to facilitate the desired health and safety outcomes as outlined in the individual's ISP.

Allowable activities must be ordered and certified as medically necessary by a Virginia-licensed physician or nurse practitioner on the CMS 485 form.

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The allowable activities for the SN service may include:

- Administering medications and other medical treatments by medical professionals ordered specifically for the individual's care,
- Skilled training of family members, caregivers, and other relevant persons regarding the nursing care of the individual,
- Monitoring an individual's medical status including assessment and observation related to the individual's nursing care and treatment needs specific to the medical orders, desired health outcomes, and the support activities outlined in the individual's ISP,
- Providing consultation and guidance to DSPs or family members/caregivers related to the individual's nursing care and treatment needs specific to the desired health outcomes and recommendations for ongoing care and support activities outlined in the individual's ISP,
- Delegation of nursing tasks to unlicensed paid caregivers (i.e., DSPs) in accordance with nurse delegation regulations in 18VAC90-19 240 – 280.

Examples of Nurse Delegated Activities:

- Care of a colostomy to provide the proper care for skin protection to reduce the risk of stoma related complications. Activities may include, but might not be limited to, changing, emptying, or cleaning the pouch system and related documentation.
- Provision of supplemental oxygen to increase the concentration of inhaled oxygen to reduce the risk of hypoxia. Activities may include, but might not be limited to, managing parts of the oxygen system ordered such as an oxygen concentrator, nasal cannula or simple face mask, or utilizing a pulse oximeter to measure oxygen levels of the blood and related documentation.
- Assuring that all items listed above are carried out in accordance with the plan for supports.

Service Limitations

The Skilled Nursing service must be ordered by a physician or nurse practitioner and must be medically necessary. The medical necessity for Skilled Nursing services is documented in the individual's ISP. Once it has been determined by a physician or nurse practitioner that medical necessity can no longer be demonstrated, this service must be terminated and the ISP updated to reflect the change in status.

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SN service cannot be provided unless the individual has exhausted all of the home health benefits available to them under the Commonwealth's Medicaid benefit or other benefit available to the individual.

SN may not be authorized or billed concurrently with private duty nursing except if nurse delegation activities in accordance with 18VAC90-19-240-280 are required by the individual and included in the individual's ISP.

The SN service is a one-to-one service. It is not a group service and thus the services of the nurse may be billed for only one individual at a time.

Examples of Allowable Service Delivery and Billing When There Are Multiple Individuals in the Setting:

Two individuals living in the same residence:

- Individual A requires 6 hours of SN a week and Individual B requires 6 hours of SN a week. SN is delivered to one person at a time.
- The residence schedules their nurse 12 hours a week to provide the service for both Individual A & B and bills 12 hours a week of SN.

Service Units

SN is rendered and billed in quarter-hour (15 minute) increments.

Service Documentation Requirements

Skilled Nursing providers shall include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate DBHDS–approved SIS® assessment form or other approved, developmentally appropriate assessment according to the individual's age;
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired health outcomes that describe what is important to and for the individual in observable and measurable terms, particularly related to the individual's diagnoses and relevant medical history;
 - Support activities and support instructions, including nursing tasks and monitoring, as well as nurse delegation, as appropriate, that are designed to assist in achieving the individual's desired outcomes;

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- The services to be rendered, including specific consultation and guidance activities, and the schedule of 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 needs for services; and
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.
- Documentation of who was trained on the nursing service plan, including family/caregivers or staff, or both. This documentation must indicate the dates and times and the content of the training. Training of professional staff and/ or family members as appropriate, must be consistent with the Regulations Governing the Practice of Nursing (18VAC90-19-280);
 - Documentation of the Physician or Nurse Practitioner orders must be completed every six months. This means that the CMS 485 and the individual plan for supports related to SN services must be updated every six months;
 - Documentation must support billing. This includes documentation that justifies the SN services and clearly describes the amount and type of nursing interventions provided, results of interventions/treatments, and the specific dates and times of nursing interventions and appropriate signatures;
 - Documentation that affirms that the skilled nursing services are provided as a one-to-one service in accordance with the plan for supports;
 - In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;

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- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.
- The content of each review must be discussed with the individual and family member/caregiver, as applicable, and submitted to the Support Coordinator within ten (10) calendar days following the end of each quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator.
 - The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, by the individual, and/or family member/caregiver's signature on the review, as appropriate , or in a progress note describing the discussion;
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS; and
 - Written documentation of all contacts with the individual's family/caregiver, physicians, providers, and all professionals regarding the individual, as well as written confirmation in the form of a signature from the individual or family that they received services.

Provider documentation must clearly reflect the skilled nursing service authorized and provided and support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by the ISP and the provider's documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

THERAPEUTIC CONSULTATION

Service Definition/Description

Therapeutic consultation service means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavior analysis/consultation, speech-language pathology therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy disciplines that are designed to assist individuals,

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parents, guardians, family members, and any other providers of support services with implementing the ISP.

This service provides assessments, development of a therapeutic consultation support plan, and teaching in any of these designated specialty areas to assist family members, caregivers, and other providers in supporting the individual enrolled in the waiver.

A “therapeutic consultation support plan” is the assessment-based report of recommendations resulting from a therapeutic consultation that is developed by the professional consultant after he spends time with the individual to determine the individual's needs in his area of expertise. It provides guidance for those who support and care for the individual on how to implement strategies developed by the consultant in order to better support the individual. It is distinct from the plan for supports.

Criteria/Allowable Activities

Therapeutic consultation service is covered in the FIS and CL waivers. To qualify for therapeutic consultation service, the individual must have a documented need for consultation. This means that the ISP cannot be implemented effectively and efficiently unless this form of therapeutic consultation is authorized and provided. The need for this service must be based on the individual's ISP and clinically necessary to the individual. Therapeutic consultation service may be provided in individuals' homes, day support programs, and in other community settings, where they will facilitate implementation of individuals' desired outcomes as identified in their ISP.

Allowable activities for this service may include:

- Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation;
- Observing the individual in daily activities and natural environments and observing and assessing the current interventions, support strategies, or assistive devices being used with the individual;
- Assessing the individual's need for an assistive device for a modification or adjustment of an assistive device, or both, in the environment or service, including reviewing documentation and evaluating the efficacy of assistive devices and interventions identified in the therapeutic consultation plan;
- Developing data collection mechanisms and collecting baseline data as appropriate for the type of consultation service provided;
- Designing a written therapeutic consultation support 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

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adaptation of other training programs or activities. The plan may recommend training relevant persons to better support the individual simply by observing the individual's environment, daily routines, and personal interactions;

- Demonstrating (i) specialized, therapeutic interventions; (ii) individualized supports; or (iii) assistive devices;
- Training family/caregivers and other relevant persons to assist the individual in using an assistive device; to implement specialized, therapeutic interventions; or to adjust currently utilized support techniques;
- Intervening directly, by behavioral consultants, with the individual and demonstrating to family/caregivers or 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; and
- Consulting related to person centered therapeutic outcomes, in person, over the phone, or via synchronous video feed in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Service Limitations

- The unit of service is one hour. Providers may only bill for services rendered to one individual at a time. Group billing or concurrent billing for multiple individuals at the same date/time is not permitted;
- The services must be explicitly detailed in the plan for supports;
- Travel time and written preparation are considered as in-kind expenses, within therapeutic consultation service and will not be reimbursed as separate items. Written preparation which are “in kind” expenses includes written activities that are not included in allowable activities for the service;
- Definition of ‘in-kind’: written activities that are not included in allowable activities for the services. Examples may include a) completion of progress notes completed before or after service delivery; b) creating graphical displays not concurrent with the delivery of other allowable activities; and c) developing quarterly reports not concurrent with the delivery of other allowable activities.

Therapeutic consultation may not be billed solely for purposes of monitoring the individual, nor for direct and ongoing therapy. Therapeutic Consultation for Speech, OT, and PT cannot be billed for the purpose of initial evaluations/assessments as this is covered under the State Option Plan.

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Behavioral consultation

- Only behavioral consultation among the therapeutic consultation services may be offered in the absence of any other waiver service.
- Initial requests for behavioral consultation by a provider may not be authorized for more than 180 days. The request must include the Part V, which must outline completion of the Functional Behavioral Assessment (FBA), creation of the behavior support plan, and the plan for data collection.
- Behavioral support plans (BSP), inclusive of FBA information and results, will be submitted with the second authorization that follows the initial authorization. Any baseline data and/or treatment data will be provided with the submission of the second authorization. The request for a second authorization must include a description of training for those who support the individual in the Part V. The initial plan for training must be included in the BSP.
- For any annual reauthorization requests that follow the initial and second authorization requests, the following must be submitted:
 - Summary of quarterly data in an acceptable format (e.g., line graph);
 - Current behavior support plan (inclusive of FBA information and results and statement of validity of previous FBA or indication for reassessment to occur); and
 - Documentation of any training completed within the most recent review period.

The Part V will include training for stakeholders. Any second authorizations and annual reauthorization requests must include measurable outcomes/support activities for each behavior targeted for increase and decrease. The updated plan for training will be included in the BSP.

Other than behavioral consultation, therapeutic consultation service may not include direct therapy provided to individuals enrolled in the waiver and may not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance. Behavior consultation may include direct behavioral interventions and demonstration of such interventions to family members or staff in the presence of the individual.

For therapeutic consultation behavioral services, direct therapy consists of the behavioral consultant implementing strategies with the individual that can only be accomplished while being physically present in the same environment as the individual and cannot be accomplished via telehealth modalities. Examples may include, but are not limited to, learning opportunities where the behavioral consultant provides any type of physical guidance or gestural prompts to the individual, providing learning opportunities with materials that need to be physically manipulated by both the behavioral consultant and the individual, or demonstrating interventions to

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family/caregivers that require the behavioral consultant to be physically present in the same environment as the family/caregivers and the individual.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A copy of the completed age-appropriate DBHDS-approved SIS[®] assessment form or other approved, developmentally appropriate assessment.
- A plan for support that contains at a minimum the following elements:
 - Identifying information;
 - Desired outcomes, support activities, and timeframes; and
 - Specific consultation activities.
- A written therapeutic consultation support plan detailing the recommended interventions or support strategies for providers and/or family members/caregivers to better support the individual enrolled in the waiver in the service.
 - Behavior support plans will contain the following information, at a minimum:
 - Demographic information (e.g., name, date of birth, gender, Medicaid ID number, legal status, diagnoses, medication, current living situation, behavior interventionist and credentials);
 - Person-centered information (e.g., admirable qualities, strengths, key people in the person's life, person's goals and desires, communication method, preference assessment results, current schedule, and impact of person's health, mobility, medical status on their life and behavior, and known trauma history, if applicable);
 - History and rationale (i.e., reason for the plan and history of behavioral services and impact of services on behavior);
 - Functional behavior assessment (e.g., FBA methods utilized, location of FBA, and results);
 - Behaviors targeted for decrease;
 - Hypothesized functions of behavior (if not included in the FBA section);
 - Proactive strategies/antecedent interventions;

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- Replacement behaviors/behaviors targeted for increase;
- Consequence interventions are a minimum BSP expectation and applicable for any BSP that is targeting challenging behavior reduction and increase in desirable behaviors; inclusion of any additional information beyond other minimum content areas is at the discretion of the author of the behavior plan;
- Safety and crisis guidelines (if applicable);
- Any additional information (i.e., any other relevant information not included in other plan areas); and
- Appropriate signatures and plan for initial and ongoing training.
 - Documentation of who was trained on the plan and when and where should be maintained and a plan for ongoing training should be determined.
- Ongoing progress note documentation of rendered consultative service that may be in the form of contact-by-contact or monthly notes that must be contemporaneously signed and dated, that identify each contact including location and recipient of training activities, the amount of time spent on the activity, what was accomplished, and the professional who made the contact and rendered the service.
- Written quarterly reviews will be completed by the provider to align with the quarters of the individual's ISP. If the consultation service extends beyond one year or when there are changes to the plan for supports, the plan for supports must be reviewed by the provider with the individual, individual's family/caregiver, as appropriate, and the support coordinator and must be submitted to the support coordinator for service authorization, as appropriate.
 - For behavioral consultation, the quarterly review must include graphed data and a summary of this data;
 - For behavioral consultation, the annual review must include graphed or tabled data that is trended across the first three quarters;
 - For behavioral consultation that extends beyond one year, as a part of the shared planning meeting the behaviorist must review the FBA and treatment data and determine if the functions are still valid. A reassessment of the functions of behavior is required when data suggest treatment expectations are not being met

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or there has been a significant change in status of the individual that is negatively impacting outcomes. This must be documented in the BSP;

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS;
- Written progress note documentation of contacts made with the individual's family/caregiver, physicians, providers, and all professionals concerning the individual;
- A contemporaneously signed and dated final disposition summary that is forwarded to the support coordinator within 30 days following the end of this service and that includes:
 - Strategies utilize;
 - Objectives met;
 - Unresolved issues; and
 - Consultant recommendations.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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	CORRESPONDING REGULATION(S)	BI	FIS	CL
RESIDENTIAL OPTIONS				
Group Home Residential Services	12VAC30-122-390			✓
Independent Living Supports	12VAC30-122-420	✓		
In-Home Support Services	12VAC30-122-410		✓	✓
Shared Living Services	12VAC30-122-510	✓	✓	✓
Sponsored Residential Services	12VAC30-122-530			✓
Supported Living Services	12VAC30-122-540		✓	✓

GROUP HOME RESIDENTIAL

Service Definition/Description

Group home residential service consists 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 in the community. This service may be provided to individuals who are living in (i) a group home or (ii) the home of an adult foster care provider. The Group home residential service may be provided to the individual continuously up to 24 hours per day by paid staff who are physically present. This service may be provided either individually or simultaneously to more than one individual living in that home, depending on the required support (i.e., toileting, or other personal care activities).

Criteria/Allowable Activities

Group home residential supports are only available to those individuals on the Community Living (CL) waiver.

The allowable activities include, as may be appropriate for the individual as documented in his plan for supports:

- Skill-building and providing routine supports related to ADLs and IADLs such as hygiene supports;
- Skill-building and providing routine supports and safety supports related to the use of community resources, such as transportation, shopping, restaurant dining, and participating in social and recreational activities, and safety supports to ensure the individual's health and safety;
- Supporting the individual in replacing challenging behaviors with positive, accepted behavior for home and community environments, for example (not all inclusive):
 - Developing a circle of friends;

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- Handling social encounters with others; or
- Redirecting challenging behavior.
- Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;
- Providing routine supports and safety supports with transportation to and from community locations and resources; and
- Providing general supports, as needed.

Group home residential service must include a skill-building component along with the provision of supports as may be needed by the individuals who are receiving the service.

The following services are not allowed to be authorized during the same date range as group home residential:

- Agency Directed Respite
- Consumer Directed Respite
- Agency Directed Personal Assistance
- Consumer Directed Personal Assistance
- Sponsored Residential
- Supported Living Residential
- Shared Living
- In-home supports
- PERS
- Electronic Home Based Supports
- Environmental Modifications
- Independent Living

Individuals who receive group home residential services may also receive Agency- or Consumer-Directed Companion services; however, the group home provider may not also be the provider of Companion services, as this is duplicative. For individuals receiving group home services, companion services may not be provided by an immediate family member.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to

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the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Limitations

The number of licensed beds in a setting reimbursed for group home residential services must not exceed six (6). Group home settings larger than six licensed beds which became DD waiver providers prior to March 31, 2021 may continue to operate and receive Medicaid reimbursement. DMAS may, with the agreement of DBHDS, authorize temporary exceptions to the maximum limit if the site can reasonably accommodate a larger number and if there exists an unforeseen set of circumstances which makes the continuity of care possible only if the exception is made. In compliance with 12VAC35-105-530 G the provider must notify DBHDS Licensing of emergency evacuations after the disaster or emergency is stabilized. The provider should report to DBHDS no later than 24 hours after the incident occurs. It will be the decision of DBHDS Office of Licensing if the circumstances warrant a temporary increase in capacity; it will be the decision of DMAS if billing can occur for services provided while the capacity exceeds six beds.

This process needs to be treated as an emergency situation.

If a group home larger than six licensed beds changes ownership, it will be considered a new setting and the licensed bed capacity limit of six beds will apply for Medicaid reimbursement purposes.

Group home residential services will be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports. Those services authorized for reimbursement under Group home residential services may not duplicate those that are funded or provided by another source.

Group home residential services may not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in Nursing Facilities, ICF/IIDs, hospitals, or assisted living facilities. Providers will only be reimbursed for the tier to which the individual has been assigned based on the individual's assessed needs and according to the number of beds in the home. Reimbursement will not include the costs of room and board.

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Service Units

The unit of service is one day. Providers may bill the unit of service if any portion of the plan for supports is provided during that day. Billing may not exceed 344 days per ISP year in accordance with the established rate structure.

If an individual moves to a group home with a different provider agency during their ISP year, the 344 days count resets to one on the first day the individual is living with the new provider agency. If an individual moves from one home to another within the same provider agency during their ISP year, the 344 day count does not reset.

Group home residential service is a tiered service for reimbursement purposes, based on the individual's assigned level and tier and the licensed bed capacity of the home. If the number of licensed beds in a group home residential setting changes, a new service authorization request must be submitted.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS[®] assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and

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- Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations and the HCBS settings requirements of 42 CFR 441.301.
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the services outlined in the plan for supports must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
- Documentation must correspond with billing as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of reimbursement made.
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

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- Any significant events.

The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. Each quarterly review will represent the quarterly data however, the fourth quarter will provide an annual summary in addition to the fourth quarter data.

- The annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS;
 - Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;
 - For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.

INDEPENDENT LIVING SUPPORT SERVICES

Service Definition/Description

Independent living (IL) means a service provided to adults 18 years of age and older that offers targeted skill building and supports necessary for individuals to secure and maintain their own home in the community. An individual receiving this service typically lives alone or with roommates in the individual's own home or apartment. The supports may be provided in the individual's residence or in other community settings.

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Criteria/Allowable Activities

Individuals eligible for this service must be enrolled in the Building Independence (BI) waiver and living in his or her own home or apartment. The need for IL supports must be clearly indicated in the ISP. Independent living support service will be authorized for Medicaid reimbursement only when the individual requires this service and the service is set out in the plan for supports. This service must include a skill building component along with the provision of supports as needed.

Allowable activities include:

- Skill building and supports which will promote the individual's stability in his own home and community in the absence of a primary caregiver living in the home. This may include skill building and supports in areas such as:
 - Cooking
 - Cleaning
 - Shopping
 - Food Preparation and healthy eating
 - Money management
 - Organization
 - Calendar skills
 - Transportation
 - Coordinating/Scheduling Appointments
- Skill building and supports to promote the individual's community participation and inclusion in meaningful activities;
- Skill building and supports to increase socialization skills and develop/maintain relationships;
- Skill building and supports to improve and maintain the individual's health, safety and fitness, as necessary;
- Skill building and supports to promote the individual's decision making and self-determination;
- Skill building and supports to improve and maintain, as needed, the individual's skills with ADLs and IADLs;

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- Routine supports with transportation to and from community locations and resources; and
- General supports, as needed.

Independent Living is compatible with all services available in the BI Waiver.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the Virginia SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Limitations

Individuals generally receive up to 21 hours of IL supports per week (Sunday through Saturday) in the individual's home or community settings. Because this service is billed on a monthly (or partial month) basis, if the individual does not receive the full 21 hours one week due to a documented reason (e.g., vacation, hospitalization, illness, refusal), additional hours may be provided, if the individual has a documented need, another week in the month.

This service may not be provided in a licensed residential setting.

Service Units

The IL service unit of service delivery is one month or, when beginning or ending the service, may be a partial month. The partial month unit is billed when fewer than 10 days of IL are delivered in one month. Sufficient hours of service must be provided to meet the requirements set forth in the plan for supports.

Example 1: an individual moves into his apartment on March 23rd. ILS is delivered every day from March 23 through March 31. The provider would bill the partial month rate.

Example 2: an individual has experienced a decline in health and is moving to a group home through the CL waiver. Her apartment move-out date is December 5th. The ILS provider delivered five days of support in December and may bill a partial month.

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Service Documentation Requirements

The required documentation for IL is as follows:

- A completed copy of the age appropriate, DBHDS-approved SIS[®] assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations;
 - Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available and documented at the time of contact. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

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- Documentation must support billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of payments made.
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable, and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

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- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

IN-HOME SUPPORT SERVICES

Service Definition/Description

In-home support service (IHSS) is a residential service that takes place in the individual's home, family home, or community settings that typically supplements the primary care provided by the individual, family, or other unpaid caregiver and is designed to ensure the health, safety, and welfare of the individual. The individual must be living in his own home or his family home, and must be able to hire and fire providers of this service without having to move. This service must include a skill building component, along with the provision of supports that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills required for successfully living in his community. In-home support service is available to individuals through the FIS and CL waivers.

Criteria/Allowable Activities

To be eligible for IHSS, individuals must require help with adaptive skills necessary to reside successfully in home and community-based settings. In-home support service will be authorized for Medicaid reimbursement only when the individual requires this service and the service is set out in the plan for supports.

Allowable activities include the following as may be appropriate for the individual as documented in his plan for supports:

- Skill-building and routine supports related to ADLs and IADLs;
- Skill-building, routine supports, and safety supports related to the use of community resources, such as transportation, shopping, dining at restaurants, and participating in social and recreational activities;

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- Supporting the individual in replacing challenging behaviors with positive, accepted behaviors for home and community environments;
- Monitoring the individual's health and physical condition and providing routine and safety supports with medication or other medical needs;
- Providing supports with transportation to and from community sites and resources; and
- Providing general supports as needed.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the Virginia SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional in-home supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Limitations

In-home support services may not typically be provided 24 hours per day, but may be authorized for brief periods up to 24 hours a day when necessary and supported through documentation.

All individuals must have a backup plan prior to initiating services in cases of emergency or should the provider be unable to render services as needed. This backup plan must be shared with the provider and support coordinator at the onset of services and updated with the provider and support coordinator as necessary.

This service may not be provided in a licensed residential setting, such as a supported living program or group residential. The individual must be able to hire and terminate the provider of this service.

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Individuals may have IHSS, personal assistance service, and respite service in their ISP, but may not receive these Medicaid-reimbursed services simultaneously (i.e., on the same dates and times).

Services that may not be authorized with IHSS include:

- Supported Living
- Sponsored Residential
- Group Home Residential

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving IHSS have various available natural supports, service provider resources, and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person. The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

- The appropriate explanation such as clear notation of the insufficiency of the back-up plan; and
- Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery. Because IHSS is authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Service Units

The unit is one hour and is reimbursed according to the number of individuals served.

This service may be provided to up to three individuals per residential setting. In-home support services is not a tiered service for reimbursement purposes; however, per person reimbursement

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decreases with each additional person receiving services according to the approved rate methodology. In-home support services do not include room and board. Services authorized for reimbursement may not duplicate those that are funded or provided by another source.

The in-home support service is reimbursed for the time the DSP is working directly with the individual. Total billing cannot exceed the total hours provided and authorized on the service authorization request. When unavoidable circumstances occur so that a provider is at the individual's home at the designated time but cannot deliver part of the services due to individual or family related situations (such as unanticipated lateness or illness of the individual or family emergency), billing will be allowed for the entire number of hours scheduled for that day. The provider must maintain documentation of the date, times, services that were provided and specific circumstances, which prevented provision of all of the scheduled services. If fewer hours than scheduled in the Plan for Supports are delivered on a regular basis over a 90-day period, the provider must revise the Plan for Supports and submit a new service authorization request. This revision must be reviewed and approved by the support coordinator and authorized by DBHDS.

Service Documentation Requirements

The required documentation for in-home supports services is as follows:

- A completed copy of the standard, assessment form (DBHDS-approved developmental assessment or SIS[®] assessment form, depending on the individual's age),
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

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- An attendance log or similar document that is maintained and that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
- Documentation must correspond with billing as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

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- Any significant events.
- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the ISP and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year.
 - For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
 - All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator/case manager, DMAS, and DBHDS.
 - Written documentation of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
 - For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
 - Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

SHARED LIVING SUPPORTS

Service Definition/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 shall be set out in a detailed, signed and dated agreement between

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the individual and roommate. This service shall require the use of a Shared Living provider (provider agency) enrolled with DMAS. This provider shall be responsible for directly coordinating the services and directly billing DMAS for reimbursement. Shared living services shall be covered in the CL, FIS and BI waivers.

Criteria/Allowable Activities

Shared Living is a one to one arrangement with one roommate providing supports to one individual receiving waiver services. The individual shall select his roommate and together through a person-centered planning process, they shall determine the assistance to be provided by the roommate based on the individual's needs and preferences. The need and choice for the service option will be documented in the individual's person-centered ISP.

- The Shared Living service requires a written agreement between the individual and roommate to cover the following areas: Participation between the individual and the roommate:
 - Specification of the agreed upon type, amount, frequency and delivery of fellowship and companionship supports that will be provided to the individual;
 - Documentation of the *Activities of Daily Living(ADLS)* and *Instrumental Activities of Daily Living (IADLs)* supports to be provided, which may account for no more than 20% of the anticipated time agreed upon between the individual and the roommate;
 - Specification of the preferences of both the individual and the roommate and the agreed upon duties in the residence that will be shared by both.

This agreement shall not include terms or conditions that are disallowed by the waiver or by any other regulatory authority. The roommate will not have responsibility for providing habilitative or medical services.

The reimbursable room and board subsidy for the roommate shall be established through the service authorization process per the CMS-approved rate methodology published on the DBHDS website. Reimbursement will not be made directly to the individual, but routed to the individual through the provider that will in turn transfer the appropriate amount of funds to the individual to cover the roommate's room and board costs. Arrangements for disbursement of funds to cover household expenses will be determined by the individual and the roommate.

The Shared Living provider must complete a background check on the roommate, including but not limited to, a criminal registry check. The roommate must not have been found guilty of having committed any barrier crimes in accordance with both § 37.2-416 – and § 19.2-392.02 of the Code of Virginia. If the roommate is found to have been convicted of a barrier crime, he is no longer eligible to receive Medicaid funding for room and board.

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The supports agreement between the individual and roommate, must include a back-up plan in the event that the roommate is unable or unavailable to provide the agreed upon supports. The backup plan may include the family and/or friends of the individual, or if required by the plan, waiver services and supports available to the individual may be temporarily increased during the time the roommate is unavailable. Family members providing back-up support are not responsible for documentation of supports provided.

The individual must reside in his own home or in a residence he leases. A signed, executed copy of the lease agreement, completed Shared Living Attestation form, and documentation of roommate training and background checks (which may not under any circumstances, be shared or transmitted) must be submitted with the service authorization request for the Shared Living service.

Shared Living requires oversight by a provider that will be responsible for quarterly face-to-face monitoring of the service with monthly collateral contacts. The provider and Support Coordinator share oversight of the service through traditional monitoring oversight activities.

- The provider and the Support Coordinator shall work together to monitor the arrangement to ensure that supports are provided as agreed and communicate any problems or issues that arise for appropriate resolution;
- The Support Coordinator and provider shall help mediate and mitigate conflicts that arise,
- The provider and the Support Coordinator are not responsible for removal of the roommate from the residence. This will depend on the tenancy status of the roommate, as dictated by the lease;
- The property owner or law enforcement would intervene, as necessary in the event of criminal or other prohibited activity;
- The provider may access flexible funding for set up activities related to roommate screening and matching for initiation of the service at the current case management rate up to 60 days prior to service authorization. Please see flexible funding guidelines for more information;
- In the event that the roommate exits the arrangement prior to the end of the lease or as outlined in the Supports Agreement, the individual may receive up to 60 days reimbursement through flexible funding for the roommate's portion of the rent to locate a new roommate.

The allowable activities may include:

- Companionship supports, which are further described as:

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- The provision of *fellowship*, which means to engage the individual in social, physical or mental activities, such as conversation, games, crafts, accompanying the person on walks, errands, appointments and social and recreational activities.
- Enhanced feelings of security which means to provide necessary social and emotional support to the individual when inside or outside of the residence.
- Limited ADL and IADL supports, which may account for no more than 20% of the anticipated time agreed upon between the individual and the roommate. These are further described as:
 - Assistance with IADLs which are tasks that enable a person to live independently at home, such as meal preparation, light housework, assistance with the physical taking of medications.
 - Assistance with ADLS, either with routine prompting and/or intermittently providing direct assistance for ADLs such as dressing, grooming, feeding, bathing, toileting and transferring.

Service Limitations

- The service is limited to adult individuals aged 18 or above;
- The individual must reside in his or her own home or a leased residence and be named as primary leaseholder;
- Individuals must be receiving at least one other waiver service;
- The roommate must be at least 18 years of age;
- There may be no inherent or explicit employment relationship between the individual and the roommate with no compensation given to the roommate by the individual (or the individual's authorized agents);
- The roommate may not be a service provider to the individual for any waiver service, but he may provide services to another individual;
- The roommate may not be the spouse, parent (biological, adoptive, foster, or stepparent), grandparent, or guardian of the individual;
- The roommate must successfully meet or exceed the training requirements set out in the written agreement, including but not limited to:
 - CPR training;
 - Safety awareness;

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- Fire safety and disaster planning; and/or
- Conflict management and resolution.
- Service interruptions will not exceed 60 days to continue eligibility for Shared Living.
- When the Shared Living provider agency determines that their participation as administrative provider for an individual enrolled in the waiver will be discontinued, the provider must give the individual and the individual's family/caregiver, and/or guardian, as appropriate, and the individual's support coordinator, advance written notification of the provider's intent to discontinue services.

Because two individuals' housing may be impacted by discontinuation/interruption of the Shared Living service, the notification letter must be submitted by the provider for receipt by the individual at least 60 days in advance of the effective date of the planned discontinuation of service. The notification letter must outline the reasons for discontinuing participation in the service.

- Immediately upon receiving the advance notice of the discontinuation of the service, the support coordinator will assist the individual enrolled in the waiver in obtaining authorization of the Shared Living service from another enrolled provider.

The subsidy payment will not be made when the individual lives in the roommate's home, in a residence that is owned or leased by a provider agency, or any other residential arrangement where the individual is not directly responsible for owning or leasing the residence. The Shared Living subsidy payment shall not duplicate:

- Services that are required as a reasonable accommodation under any applicable federal statute;
- Payments made to public agencies or private entities under other program authorities for this same purpose;
- Any other Medicaid waiver service.

Services incompatible with the Shared Living service includes:

- Group Home;
- Sponsored Residential;
- Supported Living Residential Services; and
- Respite Services.

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Service Units

The unit of service shall be a month or may be a partial month for months in which the service initiates or ends. A partial month will be used for calculation of the first month's rent when the service is terminated on days 1 through 10 or initiated on day 16 through the end of the month.

Reimbursement for Allowable Expenses

The approvable amount for the room and board subsidy (rent, food and utility costs) shall be the lesser of the roommate's half of the rent cost incurred by the individual receiving waiver services up the maximum allowable amount for the region of the state in which the individual and roommate reside. The maximum reimbursable room and board shall be based on the range of fair market rent (FMR) in the state, using one rate for Northern Virginia and another for the rest of the state (ROS) as established by DMAS.

The reimbursement for up to 50% of the cost of rent and utilities incurred by the individual for the roommate's portion cannot exceed amounts shown in the table below:

Rent/utilities Reimbursement	Rest of State	N. Virginia
Reimbursement for up to 50% of <u>rent & utilities</u> up to the maximum allowance for the ROS and Northern Virginia. Utilities are reimbursed at a flat rate up to \$100 per unit per month. The \$100 utility allowance is applicable under the following conditions: • <u>The individual does not receive rental assistance*</u> • The individual's rent is below market for the geographic area and is added to the rent to achieve reimbursable FMR** • Utilities are not included in the rent. *Individuals receiving rental assistance are not eligible for reimbursement of rent or utilities since these costs are factored into the subsidy received by the individual. Individuals receiving rental assistance may only receive	\$553.50 (maximum reimbursement for 50% of rent)	\$729.00 (maximum reimbursement for 50% of rent)

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reimbursement for food and internet (see chart below). **The FMR referenced includes the 2015 rate in accordance with the last waiver rate change. The Shared Living FMR will increase with the next waiver rate rebase.		
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The reimbursement for food and internet services is a flat rate reimbursement determined through a CMS approved rate methodology equal to the following amounts:

Expense	Monthly Reimbursement Amount
Internet Service	\$25.00 monthly reimbursement
Food	Up to \$240.90 monthly reimbursement Based on USDA Low-Cost Plan for a 19-50 year old male, June 2015. If the live-in roommate receives monthly SNAP benefits, the benefit amount would be deducted from the monthly reimbursement amount.

The localities listed below are considered “Northern Virginia” (NOVA) according to the FMR areas included in the rate methodology. Any city/county not included in the chart below is ROS.

Northern Virginia Differential Effective July 1, 2015	
Locality	FIPS Code
Alexandria City	510
Arlington County	013
Clarke County	043
Fairfax City	600
Fairfax County	059
Falls Church City	610
Fauquier County	061
Fredericksburg City	630
Loudoun County	107
Manassas City	683
Manassas Park City	685

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Prince William County	153
Spotsylvania County	177
Stafford County	179

Other Limitations

Often, in order to live in independent housing, individuals receiving waiver services require rental assistance. Rental assistance may include a Housing Choice Voucher, or a state rental subsidy from the Department of Behavioral Health and Developmental Services (DBHDS) State Rental Assistance Program (SRAP), project-based rental assistance, or the rent may be subsidized with funds from an individual's special needs trust or ABLE account.

Individuals using rental assistance with the service shall follow the PHA process for consideration of the roommate to be classified as a Live-in-aide under PHA guidelines. Individuals who receive rental assistance and participate in Shared Living will have a reduced reimbursement for the service. This is because Medicaid programs may not duplicate funding received by individuals through another public funding source.

There are different resources available to individuals, including both personal and public resources. Personal and public resources received by the individual may factor in their ability to qualify for the rental unit. Personal and public resources received by the roommate will be deducted from the allowances in the Shared Living service.

Service Documentation Requirements

- The Shared Living provider will maintain documentation of the actual rent, Shared Living Attestation, roommate training and background check, and submit it with the service authorization request for the shared living service.
- The Shared Living provider will maintain documentation of the following:
 - Executed lease agreement;
 - Ongoing monitoring of the service;
 - The agreement signed by the individual and the roommate that identifies what supports the roommate will provide. The individual's Support Coordinator must also retain a copy of this signed, executed agreement in his file for the particular individual;

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- Weekly support checklists, signed by both the individual and the roommate, documenting supports provided (see Shared Living Toolkit Appendix A);
- Documentation of the 90-day quarterly review checklists conducted in the residence with the individual and the roommate, which includes the status of the individual, satisfaction with the service, and resolution of any issues related to service provision (See Shared Living Toolkit Appendix A);
- Shared Living Attestation and Shared Living Determination form generated through the service authorization process (See Shared Living Toolkit Appendix A);
- The following completed training:
 - CPR;
 - Safety awareness;
 - Fire, safety, and disaster planning;
 - Documentation of agreement between parties on individual on conflict management and resolution; and
 - Any other necessary specialized training outlined in the person centered-plan.
- Successful completion of all background checks;
- Documentation of monthly payments made to the individual;
- The Shared Living provider shall submit monthly claims for Shared Living services reimbursement based upon the amount determined through the service authorization process.

SPONSORED RESIDENTIAL SERVICE

Service Definition/Description

Sponsored residential services (SRS) means residential services that consist of skill-building, routine supports, general supports, and safety supports provided in the homes of families or persons (sponsors) who provide supports under the supervision of a DBHDS-licensed provider. This service enables individuals to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to live a self-directed life in the community. This service may be provided to individuals up to 24 hours per day by the sponsor family or qualified staff.

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Criteria/Allowable Activities

Only individuals enrolled in the Community Living (CL) waiver may receive sponsored residential supports.

This service may only be authorized for Medicaid reimbursement when, through the person-centered planning process, sponsored residential service is determined necessary to meet the individual's needs. This service may be provided individually or simultaneously to up to two individuals living in the same home, depending on the required support.

The allowable activities may include, as may be appropriate for the individual as documented in his plan for supports:

- Skill-building and providing routine supports related to ADLs and IADLs;
- Skill-building and providing routine supports and safety supports related to the use of community resources, such as transportation, shopping, restaurant dining, and participating in social and recreational activities;
- Supporting the individual in replacing challenging behaviors with positive, accepted behavior for home and community environments, for example (not all inclusive):
 - Developing a circle of friends;
 - Handling social encounters with others; or
 - Redirecting challenging behavior.
- Monitoring and supporting the individual's health and physical condition and providing supports with medication and other medical needs;
- Providing routine supports and safety supports with transportation to and from community locations and resources;
- Providing general supports, as needed; and
- Providing safety supports to ensure the individual's health and safety.

Sponsored residential service must include a skill-building component along with the provision of routine and safety supports as may be needed by the individuals who are participating. This service must be provided on an individual-specific basis according to the ISP and service setting requirements.

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Services not allowable with SRS include:

- Agency Directed Respite
- Consumer Directed Respite
- Agency Directed Personal Assistance*
- Consumer Directed Personal Assistance*
- Supported Living Residential
- Shared Living
- In-home supports
- Personal Emergency Response Services (PERS)
- Electronic Home Based Supports
- Environmental Modifications
- Group Home Residential

*This does not include personal assistance services required while an individual is at work.

Additionally, for an individual receiving SRS, the DSP providing the following service may not be a member of the sponsored family residing in the SRS home:

- Community Coaching
- Community Engagement
- Companion services

Individuals who receive SRS may also receive Agency- or Consumer-Directed Companion services, however, the SRS provider may not also be the provider of Companion services.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Sponsored residential service settings must comply with the HCBS setting requirements per 42 CFR 441.301 and as described in Chapter II. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

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Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Limitations

Sponsored residential services must be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports.

Sponsored residential service is limited to no more than two individuals per residential setting. Providers may not bill for service rendered to more than two individuals living in the same residential setting.

Providers will not be reimbursed for the costs of room and board.

Service Units

The unit of service is one day. Providers may bill the unit of service if any portion of the plan for supports is provided during that day. Billing must not exceed 344 days per ISP year. The 344-day billing limit is intended to protect providers against lost revenue due to members' occasional absences. The rate models include a 21-day absence factor so that providers are not financially penalized when an individual is absent from the program. This approach allows providers to earn the full annual cost of services over 344 days of billing.

If an individual moves to a sponsored home with a different provider agency during their ISP year, the 344 days count resets to one on the first day the individual is living with the new provider agency. If an individual moves from one home to another within the same provider agency during their ISP year, the 344-day count does not reset.

Sponsored residential service is a tiered service for reimbursement purposes and providers will only be reimbursed for the individual's assigned level and tier.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS[®] assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;

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- Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations and the HCBS settings requirements of 42 CFR 441.301.
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
 - Documentation must correspond with billing, , as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

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- Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the ISP and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year.
 - For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
 - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
 - Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
 - For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
 - If a family member intends to become the sponsored residential provider, the "Family Member as Sponsor Provider Supporting Documentation Form" and any associated documentation must be submitted with the service authorization request.
 - Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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SUPPORTED LIVING

Service Definition/Description

Supported living is a service that typically takes place in a residential setting operated by a DBHDS-licensed provider. This denotes a location in which the individual receiving support services would typically be required to move from the location in order to choose a different provider for the type of services provided in that setting, since the site is leased or sublet to the individual by the provider-owner and continuation of supports at that site is dependent upon receiving services from the provider-owner. The above does not apply when the services is delivered in the individual's own home or apartment.

Supported living consist of skill-building, routine and general supports, and safety supports that enable the individual to acquire, retain, or improve the self-help, socialization and adaptive skills necessary to reside successfully in the community. Supported living will be authorized for Medicaid reimbursement in the plan for supports only when the individual requires this service. This service must include a skill-building component along with the provision of routine or safety supports.

Supported living will 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 individual(s) needs.

Criteria/Allowable Activities

Only individuals who are enrolled in the CL Waiver or FIS Waiver are eligible for Supported Living.

Allowable Activities:

- Skill-building and routine supports related to ADLs and IADLs;
- Skill-building and routine and safety supports related to the use of community resources such as transportation, shopping, restaurant dining, and participating in social and recreational activities. The cost of participation in the actual social or recreational activity will not be reimbursed by Medicaid;
- Supporting the individual in replacing challenging behaviors with positive, accepted behaviors for home and community-based environments, for example (not all inclusive):
 - Developing a circle of friends,
 - Handling social encounters with others, or
 - Redirecting challenging behavior.

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- Monitoring and supporting the individual's health and physical conditions and providing supports with medication or other medical needs;
- Providing routine supports and safety supports with transportation to and from community locations and resources;
- Providing general supports as needed;
- Providing safety supports to ensure the individual's health and safety, and
- Providing administrative supports that occur without the individual present. These services can include: scheduling healthcare appointments, benefits management, and speaking with apartment management (as needed).

These services **must** include a skill-building component along with the provision of supports.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Limitations

Supported living shall be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports. This service shall be provided on an individual-specific basis according to the ISP and service setting requirements. Those services authorized for reimbursement under supported living residential services may not duplicate those that are funded or provided by another source.

Reimbursement shall not occur for the costs of room and board. Medicaid reimbursement shall be available only for supported living residential services, other than the administrative services noted above, provided when the individual is present and when an enrolled Medicaid provider is providing the services.

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Supported living residential service shall not be used solely to provide routine or emergency respite care for the individual's family/caregiver with whom the individual lives.

Services that may not authorized with Supported Living include:

- Agency Directed Respite
- Consumer Directed Respite
- Agency Directed Personal Assistance *
- Consumer Directed Personal Assistance *
- Sponsored Residential
- Group Home Residential
- Shared Living
- In-Home Supports
- PERS
- Electronic Home Based Supports
- Environmental Modifications

*This does not include personal assistance services required while an individual is at work.

Individuals who receive supported living residential services may also receive Agency- or Consumer-Directed Companion services; however, the Supported Living provider may not also be the provider of Companion services, as this is duplicative. For individuals receiving Supported Living, companion service may not be provided by an immediate family member.

Service Units

The unit of service is one day. Providers may bill the unit of service if any portion of the plan for supports is provided during that day. Billing must not exceed 344 days per ISP year. The 344-day billing limit is intended to protect providers against lost revenue due to members' occasional absences. The rate models include a 21 day absence factor so that providers are not financially penalized when an individual is absent from the program. This approach allows providers to earn the full annual cost of services over 344 days of billing.

If an individual moves to a supported living program with a different provider agency during their ISP year, the 344 days count resets to one on the first day the individual is living with the new provider agency. If an individual moves from one home to another within the same provider agency during their ISP year, the 344 day count does not reset.

Service Documentation Requirements

The required documentation for Supported Living is be as follows:

- A completed copy of the age-appropriate, DBHDS-approved SIS[®] assessment form;

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- The provider's Plan for Supports containing, at a minimum, the following elements:
 - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
 - The services to be rendered and the schedule of 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 needs for services;
 - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations and the HCBS settings requirements of 42 CFR 441.301.
- Documentation must correspond with billing as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation

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was completed and also include the date the services were provided within the body of the note.

- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the ISP and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers and all professionals concerning the individual.

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- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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	CORRESPONDING REGULATION(S)	BI	FIS	CL
SELF-DIRECTED AND AGENCY-DIRECTED OPTIONS				
Agency Directed Companion Services	12VAC30-122-340		✓	✓
Agency Directed Personal Assistance Services	12VAC30-122-460		✓	✓
Agency Directed Respite Services	12VAC30-122-490		✓	✓
Consumer Directed Services Facilitation	12VAC30-122-500		✓	✓

COMPANION SERVICES: AGENCY-DIRECTED AND CONSUMER-DIRECTED

Service Definition/Description

Companion service provides non-medical care, socialization, or general support to adults 18 years or older. This service is provided either in the individual's home or at various locations in the community.

Criteria/Allowable Activities

Companion services are available for adults who receive the CL or FIS waiver.

Companion services must be provided in accordance with the individual's plan for supports to meet an assessed need of the individual for assistance with IADLs, community access, reminders for medication self-administration, or for support to ensure his or her safety. Companion services are not permitted to be provided for purely recreational purposes.

Companion services may be provided and reimbursed through either an agency-directed or consumer-directed model or a combination of the two. If an individual chooses a combination of agency-directed and consumer-directed supports, the services can be provided on different days or at different times on the same day; however, the services must not be provided on the same days at the same time.

Should an individual elect to receive companion services through the **consumer-directed model**, there are certain requirements that must be met prior to starting services. **For more information, review the "CD Services in Virginia" section.**

All service models individually - are limited to eight hours in a twenty-four hour period. In the consumer-directed model any combination of respite, personal assistance and companion services will be limited to 40 hours per week for a single EOR (see) by the same companion. Companions who live full – or substantial amounts of time - with the individual will not be limited to 40 hours per week per EOR (see <http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship>).

Companion services are available for individuals for whom skill building is not the primary objective or when skill-building is received in another service or setting. This service may not supplant an appropriate skill-building service when the individual has the capacity to gain

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increased independence (i.e., the individual should access skill-building services as identified to satisfy the need for waiver services)

Companion services may be approved for individuals who are living in a residential setting such as a group home, supported living, or sponsored residential setting if the service need is documented in the plan for supports and does not duplicate services which should be provided by the residential agency.

Allowable activities include:

- Routine supports for IADL needs, including meal preparation, community access and activities, and shopping. Companions provide supports to broadly address any/all supports within the plan for supports, which may address more than IADL's;
- Routine supports with light housekeeping tasks, including bed making, laundry, dusting, and vacuuming, when such services are specified in the individual's plan for supports and are essential to the individual's health and welfare in order to maintain the individual's home environment in an orderly and clean manner;
- Support needed by the individual to participate in social, recreational, or community activities;
- Accompanying the individual to appointments and meetings; and
- Safety supports in the home and community setting, including supporting the individual with self-administration of medications.

Services performed for the convenience of other members of the household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, family laundering, etc.) are not allowable.

Service Limitations

A companion is not permitted to provide nursing care procedures, including care of ventilators, tube feedings, suctioning of airways, external catheters, or wound care.

A companion may not provide routine support with ADL needs.

Companion services may not be provided at the same time as personal assistance or respite services.

Persons rendering the companion service for reimbursement by DMAS must not be the individual's spouse.

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Provision of Services to More Than One Individual Receiving Companion Services in the Same Household

For services provided in the home when more than one individual receiving companion services lives in the same household, the provider/SF will assess the needs of all individuals independently. Plans for Supports will be developed detailing the amount of time required for each individual for those tasks which must be provided one-to-one, such as assistance with self-administration of medication. For households in which there are two or more individuals receiving DD Waiver services from the same companion/CD employee, the amount of time for tasks which could and should be provided for both individuals at the same time (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and shared on both Plans for Support.

When two or more individuals who live in the same home request services, the following rules will apply:

- Plans for Support include hours that are unique to each individual for one-to-one tasks and each individual will receive the number of hours required for these in his/her Plan for Supports,
- Time for IADLs such as cooking, housekeeping, grocery shopping, etc., are to be combined, and the hours split between the Plans for Support. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each Plans for Support,
- Safety supports hours are to be split between Plans for Support unless there is justification for one-on-one supervision, and
- The individuals have the right to choose separate providers to provide supports. In this event, follow rules in the first two bullets.

In no circumstances will a companion/CD employee supporting two individuals in the same household be paid for more hours than that person worked during a day.

Companion must not be authorized for anyone younger than 18 years of age. Companion services must not be provided by adult foster care providers or any other paid caregivers for an individual residing in that foster care home. For an individual receiving sponsored residential service, companion service must not be provided by a member of the sponsored family residing in the sponsored residential home.

For an individual receiving group home service, sponsored residential service, or supported living service, companion service must not be provided by an immediate family member (see 12VAC30-122-20).

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Companion services will not be authorized for family members to sleep either during the day or during the night unless the individual cannot be left alone at any time. Companion services must be required to ensure the individual's safety due to a clear and present danger to the individual as a result of being left unsupervised.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving Companion Services have various available natural supports, service provider resources, and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person. The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

- The appropriate explanation such as clear notation of the insufficiency of the back-up plan, and
- Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery. Because Companion Services is authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Service Units

The unit of service for companion services is one hour. No more than eight hours per 24-hour day, regardless of service delivery model, may be authorized. The hours to be authorized must be based on the individual's assessed and documented need as reflected in the Plan for Supports. CD employees/attendants are paid at an hourly rate through the F/EA. EORs do not receive compensation for their services.

CD companion services, in conjunction with personal assistance and respite, for one individual is limited to 40 hours per week for an EOR by the same CD employee. An individual may receive

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more than 40 hours per week of companion service, if needed, through multiple CD employees/attendants. This limitation does not apply to CD employees/attendants who live with the individual, either full-time or for substantial amounts of time. As noted above, (See <http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship>) work no more than 16 hours in a 24-hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

Companion services, whether agency-directed or consumer-directed, are reimbursed only when the individual is present, a qualified provider/CD employee is performing the services, and the allowable activities as outlined in the section “Allowable Activities” have been authorized according to an approved Plan for Supports. The only exception under the consumer-directed model is when the CD employee participates in training at the request of the individual or family member, caregiver, or EOR, as appropriate, that relates directly to the employee’s ability to provide support to the individual and the individual’s needs. Documentation of these requests and of attendance at a training must be kept in the individual’s record.

Service Documentation Requirements

The required documentation for agency-directed companion service providers is as follows. These records must be separated from those of other non-waiver services, such as home health services and must correspond with the actual billing.

- The most recently updated Provider Agency Plan of Care form (DMAS-97A/B), accompanied by the Personal Preferences Tool, or the Plan for Supports. that includes;
 - The individual's desired outcomes which describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes;
 - 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.
- A completed copy of the DBHDS-approved, age appropriate SIS® assessment.

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- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur.
- Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
- Documentation of supervision that is completed, signed by the staff person designated to perform the supervision and oversight, and includes the following:
 - Date of contact or observation;
 - Person contacted or observed;
 - A summary about the companion's performance and service delivery; and
 - Any action planned or taken to correct problems identified during supervision and oversight.
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if outcome status is maintained as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

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- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.
- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each ISP plan quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review shall be documented either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.

Required documentation for CD Companion:

- CD employees/attendant must complete bi-weekly timesheets for submission to the F/EA.
- Services facilitation documentation requirements as found in the Services Facilitation section of this chapter.

PERSONAL ASSISTANCE: AGENCY-DIRECTED AND CONSUMER-DIRECTED

Service Definition/Description

Personal assistance service means direct support or supervision with (i) ADLs, (ii) IADLs, (iii) access to the community, (iv) monitoring the self-administration of medication or other medical needs, (v) monitoring health status and physical condition, or (vi) work or postsecondary school-related personal assistance. Personal assistance service supports individuals with DD who have physical, behavioral, and/or cognitive challenges.

Personal assistance services may be provided through an agency-directed (AD) or consumer-directed (CD) model or a combination of the two. If an individual chooses a combination of agency-directed and consumer-directed supports, the services can be provided on different days or at different times on the same day; however, the services must not be provided on the same days

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at the same time. These 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 and participate in community activities.

Criteria/Allowable Activities

In order to qualify for the service, the individual must require assistance with ADLs, reminders to take medication or other medical needs, or monitoring his or her health status or physical condition. While assistance with IADLs may be included when specified in the plan for supports as needed by the individual, personal assistance for IADLs will only be authorized when the individual requires assistance with ADLs.

Personal assistance services are available for individuals for whom skill-building is not the primary objective or when skill-building is received in another service or setting. This service may not supplant an appropriate skill-building service when the individual has the capacity to gain increased independence.

Should an individual elect to receive personal assistance through the consumer-directed model, there are certain requirements that must be met prior to starting services. For more information, review the “CD Services in Virginia” section.

Allowable Activities

The allowable activities for personal assistance services include the following:

- Support with ADLs;
- Support with monitoring of health status or physical condition;
- Support with prescribed use of medication and other medical needs;
- Support with preparation and eating of meals;
- Support with housekeeping activities, such as bed-making, cleaning, or the individual's laundry;
- Support with participation in social, recreational, and community activities;
- Assistance with bowel/bladder care needs, range of motion activities, routine wound care that does not include the sterile technique, and external catheter care when trained and supervised by an RN, vital signs and recording of findings;

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- Accompanying the individual to appointments or meetings; and
- Safety supports. For a child under 18 years of age the Request for Supervision Hours in Personal Assistance form, DMAS P-257, must be submitted to DBHDS for service authorization purposes when supervision hours are requested to address safety support needs. If a participant is requesting supervision, the provider must fill this form out completely and submit it to DBHDS SA for authorization. The DBHDS SA must approve the request before DMAS will reimburse for this service.

Allowable activities for personal assistance tasks that are performed in accordance with the *Virginia Administrative Code 18VAC90-19-240 et. seq. Delegation of Nursing Tasks and Procedures and the Code of Virginia § 54.1-3001(12)* regarding health care tasks directed by the individual are also allowable. See below for additional information. For services or tasks delegated in accordance with nursing delegation requirements, the RN must be available to the assistant/CD employee and be able to respond to any complications immediately. Whenever an assistant/CD employee is performing any physician-ordered procedure, the delegating RN must document on the DMAS-99 or nursing progress note that the assistant's/CD employee's correct performance of the procedure is being observed and supervised by the RN. This must be documented at least quarterly.

Skilled Services

Services requiring professional skills or invasive therapies, such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique, cannot be performed by CD attendants/employees with the exception of skilled nursing tasks that fulfill criteria in the section "Exemption of Nurse Delegation Requirements".

Exemption of Nurse Delegation Requirements in the CD Model

For CD services, the *Code of Virginia § 54.1-3001(12)* states: "any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks" is exempted from the Nurse Practice Act and nurse delegation requirements.

Key requirements for the exemption from nurse delegation requirements, which must be performed in accordance with 18VAC90-19-240 through 18VAC90-19-280:

- Applies to **consumer-directed services only**;
- Applies to tasks that are "typically" self-performed;

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- The individual receiving service must be capable of directing the attendant in the appropriate performance of the task;
- The individual must live in a private residence; and
- The individual must be unable to perform the tasks due to a disability.

Attending to Personal Assistance Needs of Individuals Who Work or Attend Post-Secondary School or Both

The personal assistant/CD employee may help the individual prepare for and accompany the individual to work and/or post-secondary school and assist the individual with ADLs while in those settings and upon returning to the individual's residence. The assistant/CD employee may not perform any functions related to the individual completing his or her job and/or school functions nor duplicate supported employment services. Supervision/safety supports through personal assistance is not an acceptable service while the individual is at work and/or school. Personal assistance can be provided at the same time as supported employment services and both can be billed for the same days/hours.

DMAS will not provide reimbursement for personal assistance services that are required as a reasonable accommodation as part of the ADA, the Virginians with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, or if they should be provided by DARS or under IDEA. Further, if the individual's only need were for assistance during lunch, DMAS would not pay for the employee for any time extending beyond lunch. For an individual whose speech is such that he or she cannot be understood without an interpreter (not for translation of a foreign language), or the individual is physically unable to speak or make his or herself understood even with a communication device, the assistant/CD employee's services may be necessary all day.

Supervision/Safety Supports

Supervision or "safety supports" is an allowable activity for personal assistance when the purpose is to monitor the well-being of an individual who requires and has a documented need for the physical presence of the assistant/CD employee to ensure his/her safety during times when no other support system is available.

The inclusion of supervision/safety supports in the Plan for Supports for personal assistance is appropriate only in the following situations:

- The individual cannot be left alone at any time due to cognitive or physical challenges;
- The individual is unable to call for help in case of an emergency and there are no competent adults in the home who are capable of dialing 911 in the event of an emergency; and

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- To ensure the health, safety, or welfare of the waiver individual.

Supervision/safety supports will not be authorized for family members to sleep nor for family members who operate a business or work from home unless the individual cannot be left alone due to documented safety issues or wandering risk. Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual alone, or would prefer to have someone with the individual. There must be a clear and present danger to the individual as a result of being left unsupervised.

Transportation – in the CD Model

Transportation services that are not paid by the Medicaid program are coordinated between the assistant/CD employee and the individual. This includes transportation necessary to implement the Plan for Supports. It is permissible for the assistant/CD employee to transport the individual in the assistant's/CD employee's vehicle. It is advisable, but not required, that the individual or family member/caregiver, as applicable, determine if the assistant/employee has vehicle insurance that covers the insured or the other passenger for the following:

- Against loss from any liability imposed by law for damages;
- Against damages for care and loss of services, because of bodily injury to or death of any person;
- Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth, any other state in the United States, or Canada;
- Subject to a limit, exclusive of interest and costs, with respect to each motor vehicle of \$25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of \$50,000 because of bodily injury to or death of two or more persons in any one accident; and
- Subject to a limit of \$20,000 because of injury to or destruction of property of others in any one accident.

Provision of Services to More Than One Individual Receiving Waiver Services in the Same Household

For services provided in the home when more than one individual receiving personal assistance lives in the same household, the provider/SF will assess the needs of all individuals independently. Plans for Supports will be developed detailing the amount of time required for each individual for those tasks which must be provided one-to-one, such as bathing, dressing, ambulating, etc. For households in which there are two or more individuals receiving DD Waiver services from the

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same assistant/CD employee, the amount of time for tasks which could and should be provided for both individuals at the same time (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and shared on both Plans for Support.

When two or more individuals who live in the same home request services, the following rules will apply:

- Plans for Support include hours that are unique to each individual for one-to-one ADL tasks, and each individual will receive the number of hours required for these in his/her Plan for Supports;
- Time for IADLs such as cooking, housekeeping, grocery shopping, etc., are to be combined and the hours split between the Plans for Support. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each Plans for Support;
- Supervision/safety supports hours are to be split between Plans for Support unless there is justification for one-on-one supervision; and
- The individuals have the right to choose separate providers to provide supports. In this event, follow rules in the first two bullets.

In no circumstances will an assistant/CD employee supporting two individuals in the same household be paid for more hours than that person worked during a day.

Provision of Services for the Convenience of Other Members of an Individual's Household

DMAS will reimburse the assistant/CD employee for services rendered to the individual only. DMAS will not reimburse for services rendered to or for the convenience of other members of the individual's household (for example, cleaning rooms used by all family members, cooking meals for the family, washing dishes used by everyone, family laundering, etc.)

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving Personal Assistance Services have various available natural supports, service provider resources, and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person. The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an

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increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

- The appropriate explanation such as clear notation of the insufficiency of the back-up plan; and
- Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery. Because Personal Assistance Services is authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Service Units/Service Limitations

The unit of service for personal assistance is one hour. The hours to be authorized must be based on the individual's assessed and documented need as reflected in the Plan for Supports. EORs do not receive compensation for their services.

Personal assistance services, whether agency-directed or consumer-directed, are reimbursed only when the individual is present, a qualified provider/CD employee is performing the services, and the allowable activities as outlined in the section "Allowable Activities" have been authorized according to an approved Plan for Supports. The only exception under the consumer-directed model is when the CD employee participates in training at the request of the individual or family member, caregiver, or EOR, as appropriate, that relates directly to the employee's ability to provide support to the individual and the individual's needs. Documentation of these requests and of attendance at a training must be kept in the individual's record.

Individuals can receive CD/AD personal assistance, CD/AD respite care, CD/AD companion services, Group Day Services, Community Engagement Services and In-Home Residential Support services as outlined in their ISP, but the individual cannot receive these services simultaneously (i.e., on the same day at the same time).

DMAS will not reimburse personal assistance services for individuals who live in assisted living facilities or receive comparable services from another program, service, or payment source. Personal assistance services are not allowable when the individual receives any of the following services:

- Supported Living*

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- Sponsored Residential*
- Group Home Residential*

(*Exceptions may be made by DBHDS on a case-by-case basis for personal assistance services while an individual is at work.)

Consumer-directed personal assistance, in conjunction with companion service and respite, for one individual is limited to 40 hours per week for an EOR by the same CD employee. An individual may receive more than 40 hours per week of respite service, if needed, through multiple CD employees/attendants. This limitation does not apply to CD employees/attendants who live with the individual, either full-time or for substantial amounts of time (See <http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship>).

CD employees/attendants may work no more than 16 hours in a 24-hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

The individual must have a backup plan (e.g., agency, a family member, neighbor, or friend) willing and available to assist the individual in the event the assistant/CD employee does not report for work as expected or terminates employment without prior notice. This is the responsibility of the individual and family, caregiver, or EOR, as appropriate, and must be identified in the Plan for Supports. Individuals without a viable backup plan are not eligible for this service.

Scheduled Services Not Provided

The personal assistant/CD employee is responsible for following the Plan for Supports (or DMAS-97A/B and Personal Preferences tool). If the employee does not work the total number of hours during a scheduled day, as listed on the Plan for Support, the assistant/CD employee may provide supports up to the unused hours on another day/days within the same week only if:

- The individual, EOR, and/or primary caregiver, as applicable, requests that the unused time be used on another day that week; and
- The reason to carry over the hours to another day is based on a documented need of the individual. The reason cannot be to allow the assistant/CD employee to make up the unused hours of the week; and
- The total amount of hours worked during the week does not exceed the number of authorized hours for the week on the Plan for Supports (or DMAS-97A/B).

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Service Documentation Requirements

The required documentation for agency-directed/consumer directed personal assistance providers is as follows. These records must be separated from those of other non-waiver services, such as home health services:

- The most recently updated Provider Plan of Care form (DMAS-97A/B), accompanied by the Personal Preferences Tool, or the Plan for Supports that includes:
 - The individual's desired outcomes which describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions;
 - 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.
- A completed copy of the DBHDS-approved, age appropriate SIS® assessment or other approved developmentally appropriate assessment according to the individual's age;
- The initial assessment by the DBHDS-licensed agency supervisor or RN supervisory nurse completed prior to or on the date the service is initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse;
- For a child under the age of 18, the DMAS P257 (Request for Supervision Hours in Personal Assistance) form must be submitted to DBHDS for authorization purposes when supervision hours are requested to address safety supports needs;
- Written documentation (including that for the 60-day assessment period for AD personal assistance) in the form of unique, person-centered, progress/daily notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports,

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as well as specific circumstances that prevented provision of the scheduled service, should that occur.

- Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist.
- Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
- The supervisor's summarizing notes recorded and dated during any contacts with the personal assistant during visits to the individual's home;
- For CD Services documentation by the personal assistant must also include:
 - The personal assistant's arrival and departure times;
 - The personal assistant's comments or observations about the individual enrolled in the waiver to include individual-specific observations of the individual's physical and emotional condition, daily activities, and responses to services rendered, and;
 - The personal assistants and individual, 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 personal assistance services during that week have been rendered.
- The In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved or maintained as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve or improve progress is noted;
 - Information about any newly identified safety risks;

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- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason and
- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each ISP plan quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- For bowel and bladder programs, a written physician's order in the individual's file must specify the method and type of digital stimulation and frequency of administration. The RN supervisor must document that the assistant has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to a RN, and a RN has observed the assistant performing this function. The assistant's continuing understanding and ability to perform bowel and bladder programs must also be documented in the routine visit note.
- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS; and
- Written documentation of all contacts with the family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.

Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

Required documentation for CD Personal Assistance:

- CD employees/attendants must complete bi-weekly timesheets for submission to the F/EA.

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- Services facilitation documentation requirements as found in the Services Facilitation section of this chapter.

RESPITE SERVICES: AGENCY-DIRECTED AND CONSUMER-DIRECTED

Service Definition/Description

Respite service is temporary, substitute care that is normally provided on a short-term basis for temporary relief of the unpaid primary caregiver. Respite service enables an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. The maximum amount of all types of respite services designated to an individual for the unpaid primary caregiver to use is 480 hours in an individual's plan per the state fiscal year.

Respite service may be provided either through an agency-directed or consumer-directed model or a combination of the two. Respite service may be provided:

- In home and community settings, which may be based in the individual's home; or
- Under the agency-directed model by enrolled providers licensed to provide center-based respite service, to include a group home or a sponsored residential home.

Criteria/Allowable Activities

Criteria

Individuals on the Community Living (CL) and Family and Individual Supports (FIS) waivers may receive Respite services. Respite service is not an allowable service under the Building Independence (BI) waiver.

In order to qualify for the service, the individual must have an unpaid primary caregiver as per 12VAC30-122-20, who has expressed the need for relief of caregiving duties. Paid caregivers are not eligible to use respite. The individual must also require assistance with ADLs, community access, reminders to take self-administered medication or other medical needs, or monitoring his or her health status or physical condition. Respite must be listed as a needed service in the individual's ISP.

If an individual chooses a combination of agency-directed and consumer-directed supports, the services can be provided on different days or at different times on the same day; however, the services must not be provided on the same days and at the same time.

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Should an individual elect to receive respite through the consumer-directed model, there are certain requirements that must be met prior to starting services. For more information, review the “Consumer-Directed Requirements for Individual” section.

Allowable Activities

The allowable activities for respite include the following:

- Support with ADLs and IADLs;
- Support with monitoring of health status or physical condition;
- Support with prescribed use of medication and other medical needs;
- Support with preparation and eating of meals;
- Support with housekeeping activities, such as bed-making, cleaning, or the individual’s laundry;
- Safety supports;
- Support with participation in social, recreational, and community activities;
- Accompanying the individual to appointments or meetings; and
- Assistance with bowel/bladder care needs, range of motion activities, routine wound care that does not include sterile technique, and external catheter when trained and supervised by an RN.

Provision of Services to Persons in the Same Household with the Individual

DMAS will reimburse the provider/CD employee for services rendered to the individual only. DMAS will not reimburse for services rendered to or for the convenience of other members in the individual’s household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.).

Service Units/Service Limitations

The unit of service for respite is one hour. Respite as a service will be authorized for a maximum of 480 hours per state fiscal year. If an individual changes from one waiver to another during the state fiscal year and both waivers have respite as an allowable activity, the amount of respite for the individual will not reset until the next state fiscal year. Individuals who receive respite through a combination of the agency-directed and consumer-directed models or through multiple providers cannot receive more than a total of 480 hours of respite services from those combined methods. Any time provided as respite above and beyond 480 hours will not be reimbursed by DMAS.

Respite service, whether agency-directed or consumer-directed, is reimbursed only when the individual is present, a qualified provider/CD employee is performing the services, and the

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allowable activities as outlined in the section “Allowable Activities” have been authorized according to an approved Plan for Supports.

Exceptions apply under the consumer-directed model when the CD employee participates in training at the request of the individual or family member, caregiver, or EOR, as appropriate, that relates directly to the employee’s ability to provide support to the individual and the individual’s needs. Documentation of these requests and of attendance at a training must be kept in the individual’s record.

Individuals can receive AD/CD personal assistance, AD/CD respite, AD/CD companion services, and In-Home Residential Support services as outlined in their ISP, but cannot receive these services on the same day at the same time.

Respite services are not allowable when the individual receives any of the following services:

- Supported Living
- Sponsored Residential
- Group Home Residential

Respite may not be billed when the individual resides in an Assisted Living Facility or by DSS-approved Adult Foster Care providers when the individual resides in that home.

Skill development is not provided with respite service.

Neither form of respite service may include skilled nursing service, with the exception of nursing tasks that are delegated (trained and monitored) by a RN following nurse delegation regulations (18VAC90-19-240 through 18VAC90-19-280, 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). Authorization may be given for same timeframe but not delivered concurrently.

The CD respite employee cannot be the unpaid primary caregiver under any circumstance as it conflicts with the purpose of the respite service.

Consumer-directed respite, in conjunction with companion service and personal assistance, for one individual is limited to 40 hours per week for an EOR by the same CD employee. An individual may receive more than 40 hours per week of respite service, if needed, through multiple CD employees/attendants. This limitation does not apply to CD employees/attendants who live with the individual, either full-time or for substantial amounts of time (See <http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship>).

CD employees/attendants may work no more than 16 hours in a 24-hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

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The provider of AD respite services must have a back-up plan in case the respite assistant does not report for work as expected or terminates employment without prior notice. The agency will provide a back-up assistant from their internal pool or a sub-contract with another provider. The individual receiving respite services must be notified that their scheduled assistant is unavailable so that they are able to choose not to have services from a different assistant. A provider who is authorized to provide respite must have an agreement with another agency(s) when this emergency process is used that includes a reminder that all staff will meet the basic competency requirements and confirmation of a criminal background check in accordance with the requirements set forth in 12VAC30-122-120 B. The process should include, at a minimum:

- The agency that holds the service authorization will communicate to the back-up provider the specifics of the shift (time and place) where coverage is needed.
- If the back-up provider has an available respite assistant and confirms that they are available to cover the shift(s), then the supervisor from the agency holding the service authorization will communicate via phone call to the assistant who will fill the shift. During this call, the supervisor will outline the expectations of the shift and pertinent person-centered information such as the individual's preferred method of communication, allergies, dietary considerations, medical information, etc.
- The provider holding the service authorization will communicate with the individual about the change in assistants, as soon as is feasible, so that the individual can decide if they wish to receive the service or use a natural support on that day.
- If the agency that holds the service authorization is unable to provide a respite assistant for a time-period longer than 2 weeks, the provider will contact the individual's support coordinator to inform them of the difficulty meeting the person's needs.

In addition, the individual receiving either AD or CD respite must have a backup plan (for example, a family member, neighbor, or friend) willing and available to assist the individual in the event the attendant does not report for work as expected or terminates employment without prior notice. This is the responsibility of the individual and family, caregiver, or EOR, as appropriate, and must be identified in the Plan for Supports. The backup plan will be reviewed by the support coordinator to determine if it is appropriate. Individuals without a viable backup plan are not eligible for this service.

Two individuals in the same home may share supports delivered by one assistant/CD employee; however, the number of hours billed, may not exceed the number of hours the assistant/CD employee worked. When two individuals who live in the same home request respite services, the needs of both will be assessed independently and the amount of time required for each individual determined for those tasks which must be provided independently (such as bathing, dressing, ambulating, etc.). The amount of time for tasks that could and should be provided for both

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individuals simultaneously (such as meal preparation, cleaning rooms, laundry, etc.) must be combined and the hours split between the individuals.

Service Documentation Requirements for Agency Directed

The required documentation for agency-directed respite service providers is as follows. If the individual already receives personal assistance services under the waiver, one record may be maintained; however, separate sections must be reserved for the documentation of the two services. These records shall be separated from those of other non-waiver services, such as home health services:

- The most recently updated Provider Plan of Care form (DMAS-97A/B), accompanied by the Personal Preferences Tool, or the Plan for Supports that includes:
 - The individual's desired outcomes which describe what is important to and for the individual in observable and measurable terms;
 - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes;
 - 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.
- A completed copy of the DBHDS-approved age appropriate SIS® assessment or other approved developmentally appropriate assessment according to the individual's age;
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly

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documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note;

- As respite services are typically delivered on an intermittent basis, Person-centered (quarterly) reviews are required only following those quarters in which respite services are provided. If respite services are delivered, respite providers must regularly communicate with the individual's support coordinator about service provision and any related issues. The Plan for Supports must be reviewed by the provider when the individual's needs change significantly. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved and maintained, or if there has been limited or no progress. Any actions needed or that will be taken to resolve or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each ISP plan quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS;

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- Written documentation of all contacts with the family, caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

Required documentation for CD Respite:

- CD employees/attendants must complete bi-weekly timesheets for submission to the F/EA.
- Services facilitation documentation requirements as found in the Services Facilitation section of this chapter.

CONSUMER DIRECTED SERVICES & SERVICES FACILITATION

CD services, sometimes referred to as self-directed services, mean that individuals, or their representatives, if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The CD service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows individuals to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

CD services promote personal choice and control over the delivery of specific services available in DD waivers. For example, individuals are afforded the decision-making authority to recruit, hire, train, supervise, and fire the employees who furnish their services. The Centers for Medicare & Medicaid Services (CMS) calls this "employer authority."

CD Services in Virginia

There are three CD services available in the DD Waivers: CD Personal Assistance, CD Companion, and CD Respite services. The individual is the employer in these services, and, as such, is responsible for hiring, training, supervising, and firing their CD employees/attendants.

In order to ensure CD services are an appropriate option for the individual, he/she must meet the following requirements:

- The individual must have an Employer of Record (EOR). The EOR can be the individual or can be a family member, neighbor, or other person known to the individual, however, the EOR may not be the Services Facilitator. If an individual is unable to independently direct and manage his/her own CD services or if the individual is under the age of 18, the

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individual must designate another person 18 years or older to serve as the EOR. The EOR is not reimbursed by DMAS for services rendered.

- The EOR shall be the employer in this service and shall be responsible for advertising, interviewing, hiring, training, supervising, and firing CD employees/attendants. Specific EOR duties regarding the employee(s) include checking references, determining that basic qualifications are met, training, supervising performance, and submitting and approving the work shift entries to the fiscal employer agent (F/EA) on a consistent and timely basis. The EOR should monitor the individual's receipt of CD supports to ensure proper care is being provided and CD services are adequate to address the individual's needs. It is not the responsibility of DMAS or the Services Facilitator to train the CD services employee.
- The individual, the family/caregiver, or EOR, as appropriate, must have a backup plan in case the CD services employee does not show up for work or is unexpectedly terminated from employment. Individuals who do not have a documented backup plan are not eligible for this service.

The EOR for an individual cannot be the paid employee for the individual. Each EOR may only be the employer for one individual; however, an exception is allowable whereby the EOR can serve multiple individuals if those individuals all reside at the same address. The EOR is not required to reside with the individual however, the EOR should have sufficient contact in order to perform the required duties.

Additional information and guidance on being an EOR can be found in the EOR manual on the DMAS website. CD employees/attendants are not eligible at this time for Worker's Compensation.

Services facilitation agencies provide supportive services and training to EORs for the hiring, training, supervising, and firing responsibilities of the CD services employees. Services facilitation is a separate waiver service and is used only in conjunction with consumer-directed personal assistance, respite, or companion services.

Support coordinators must document in the ISP the individual's choice for the consumer-directed model and whether or not the individual chooses service facilitation. The support coordinator must document in the individual's record that the individual will serve as the EOR or that there is a need or desire for another person to serve as the EOR on behalf of the individual.

The DMAS contracted F/EA provides tools needed to support an EOR's success in managing supports and assists with employment tasks such as:

- Facilitating CD employee background checks;
- Employee record retention;

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- Processing time sheets and issuing paychecks;
- Withholding and filing employer and employee related payroll taxes;
- Compliance with Federal and State rules and regulations;
- Providing spending summaries (On-line access available).

No more than two individuals who live in the same home are permitted to share the authorized work hours of a CD personal assistance, companion or respite employee within any given employee's shift.

When two individuals who live in the same home request CD services, the Services Facilitator will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc.

An individual who has chosen consumer direction may choose, at any time, to voluntarily change one or more of their consumer directed services to the agency-directed model as long as he/she/they continues to qualify for the specific services. The services facilitator and the support coordinator are responsible for assisting the individual with the change of services from consumer-directed to agency-directed.

Involuntary disenrollment from CD services may also occur. The services facilitator or support coordinator, as appropriate, is required to initiate involuntary disenrollment from consumer direction of an individual enrolled in the waiver when any of the following conditions occur:

- The health, safety, or welfare of the individual enrolled in the waiver is at risk;
- The individual or EOR demonstrates consistent inability to hire and retain a CD employee; or
- The individual or EOR is consistently unable to manage their CD employee, as may be demonstrated by a pattern of serious discrepancies with timesheets.
- If the individual does not choose a services facilitator and a family member or other caregiver is not willing or able to assume the services facilitation duties, then the support coordinator shall notify DMAS or its designated service authorization contractor and the consumer-directed services shall be discontinued.

Prior to involuntary disenrollment, the services facilitator or support coordinator, as appropriate, shall:

- Verify that essential training has been provided to the EOR to improve the problem condition or conditions;

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- 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, as appropriate;
- Discuss with the individual and the EOR, if the individual is not the EOR, the agency-direction option that is available and the actions needed to arrange for such services while providing a list of potential providers;
- Provide written notice to the individual and EOR, if the individual is not the EOR, of the action, the reasons for the action, and the right of the individual 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; and
- If the services facilitator initiates the involuntary disenrollment from consumer-direction, the SF shall inform the support coordinator of such action and the reasons for the action.

In either voluntary or involuntary disenrollment, the individual enrolled in the waiver must be afforded the opportunity to select an agency from which to continue to receive his/her/their personal assistance, companion, or respite services. If the individual either fails to select an agency or refuses to do so, then personal assistance, companion or respite services, as appropriate, will be discontinued.

Services Facilitation

Service Definition

"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 facilitation service is a separate service and shall be used only in conjunction with consumer-directed personal assistance, respite, or companion services.

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

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If an individual choosing consumer-directed services chooses not to receive support from a CD services facilitator, then another family member or caregiver, other than the EOR, can perform all of the duties. The family member or caregiver serving as the SF will not be reimbursed by DMAS for performing these duties or meeting these requirements.

The individual's support coordinator/case manager may also function as the paid services facilitator. The support coordinator/case manager serving as the SF must meet all of the requirements of a CD services facilitator, including documentation requirements identified for services facilitation.

For transitions from the CCC Plus Waiver to a DD Waiver, to ensure a seamless transition and mitigate service interruption, a continuity of care service authorization process for personal assistance services is available. For individuals transitioning from the CCC Plus Waiver to a Community Living (CL) or Family and Individual Supports (FIS) Waiver, DBHDS service authorization staff will honor the number of hours of personal care services authorized for an individual enrolled in the CCC Plus Waiver. The period for continuity of care service authorization for CL and FIS Waiver personal assistance services is 30 days. Transitions from the CCC Plus Waiver to a DD waiver will only occur on the first day of a month. The SF has a role to play in this process in order to ensure continuity of care.

Personal assistance services continuity of care service authorization:

- The Support Coordinator contacts the individual receiving services and asks for consent for the Support Coordinator and services facilitator/agency provider to exchange information.
- The Support Coordinator contacts the MCO Care Coordinator to determine the existing number of authorized personal care hours currently in place in order to initiate the continuity of care service authorization process. If the Support Coordinator does not know who the MCO Care Coordinator is, they should call the health plan directly.
- The services facilitator/agency provider will either a) upload into WaMS the CCC Plus Waiver plan of care (DMAS 97A/B) which covers all required elements; or b) provide a summary statement to include 1) level of support required for ADLs; 2) who is the unpaid primary caregiver; 3) who is the EOR; 4) who is the staff; and finally 5) a back-up plan. The direct entry is under 'modified use' for this summary. The services facilitator/agency provider notes in the justification box in WaMS "continuity of care service authorization request."
- The Support Coordinator confirms the number of authorized personal care hours on the DMAS 97A/B is consistent with the hours reported by the MCO Care Coordinator. If accurate, the Support Coordinator submits the continuity of care service authorization request (DMAS 97A/B) to DBHDS. If the hours on the DMAS 97A/B are not consistent

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with the authorized hours, the Support Coordinator requests a revised DMAS 97A/B that reflects the currently authorized hours.

- DBHDS service authorization staff will approve the 30-day service authorization for personal assistance services for the same number of hours approved by the CCC Plus health plan on the DMAS 97A/B as for personal care or (as per the above, incorporate this detail into the summary statement.
- The services facilitator/agency provider completes and submits to DBHDS all required assessments and documentation for CL or FIS Waiver service authorization of personal assistance services by the 20th of the month that the continuity of care authorization is in effect. It is imperative that the services facilitator/agency provider submit this information timely to avoid an interruption in services and/or payment of CD employees/attendants. DD waiver service authorization requests received after the 30 day continuity of care period will result in a start date of the date the request is received, which will result in a lapse in service authorization and payment for services rendered.
- DBHDS service authorization staff process the service authorization for personal assistance services following standard operating procedures.
- For consumer-directed services, the services facilitator must submit the Fiscal Agent Request Form to the FE/A and initiate the change in fiscal employer agent, if applicable, and the change from CCC Plus Waiver services to DD Waiver services.
- The Support Coordinator provides the MCO Care Coordinator with an update on authorized services rendered under the DD waiver.
- Continued collaboration with the MCO Care Coordinator occurs to ensure appropriate, comprehensive care planning with primary and acute services.

Criteria & Allowable Activities

Providers of Services Facilitation services have an important role in assuring success in CD services and an individual's opportunity to self-direct those services. The activities below detail the requirements of providers of services facilitation services.

- Services facilitators are responsible for training EORs to direct CD services. This training should include selecting, hiring, training, supervising, and authorizing timesheets of employees providing their CD services;
- Services facilitators are responsible for making an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate. This initial home visit must include the following outcomes: (i) identification of the individual's needs for a requested consumer-directed service; (ii) assistance to the individual and the

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individual's family/caregiver, as appropriate with the development of the plan for supports with; (iii), and provision of employer management training to the EOR on his responsibilities as an employer. The service facilitator must provide employer management training to the EOR within seven days of the initial visit, if not during the context of that visit;

- The initial comprehensive home visit may 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 is approved to receive or a change in the HCBS waiver in which the individual is enrolled. If an individual changes service facilitators, the new services facilitator must complete a reassessment visit in lieu of an initial comprehensive visit;
- The employer management training must be completed before the EOR may hire a CD services employee who is to be reimbursed by DMAS;
- After the initial visit, the services facilitator is responsible for continued monitoring of the individual's plan for supports quarterly, and more often as needed - which may be conducted by telephone to prepare the quarterly report to the support coordinator. Monthly visits are not required. If CD respite services are provided, the services facilitator must review the utilization of CD respite service either every six months or upon the use of 240 respite service hours, whichever comes first;
- The services facilitator is required to have an in-person meeting with the individual at least every six months to reassess the individual's needs and to ensure appropriateness of any CD service received by the individual. During these in-person visits, the services facilitator shall observe, evaluate, and consult with the individual, EOR, and the individual's family/caregiver, as appropriate, for the purpose of assessing the adequacy and appropriateness of CD services;
- Additionally, the services facilitator, during routine quarterly visits, is responsible for reviewing and verifying timesheets, as needed, to ensure that the number of hours approved in the plan for supports are being provided and are not exceeded. If discrepancies are identified, it is expected that the services facilitator discuss these with the EOR to resolve discrepancies and notify the fiscal/employer agent that administers payroll services on behalf of the individual. If an individual is consistently identified as having discrepancies in his timesheets, the services facilitator must contact the support coordinator. Failure to review and verify timesheets and maintain documentation of such reviews shall subject the provider to recovery of payments made by DMAS.

Additional requirements and expectations for the provision of SF include:

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- The services facilitator must be available during standard business hours to the individual or EOR by telephone;
- The services facilitator will assist the individual or EOR with employer issues as requested by either the individual or EOR;
- The services facilitator must complete the assessments, reassessments, and supporting documentation necessary for consumer-directed service;
- Services facilitation will be provided on an as-needed basis as mutually agreed to by the individual, EOR, and services facilitator but, at a minimum, routine quarterly visits. Services facilitation services shall be documented in the supporting documentation for CD services, and the services facilitation provider shall bill consistent with the supporting documentation. Claims that are not adequately supported by this supporting documentation, may be subject to a DMAS recovery of expenditures;
- If an EOR is consistently unable to hire and retain a CD services employee, the services facilitator must contact the support coordinator and DBHDS service authorization to transfer the individual, at the choice of the individual, to a provider that provides Medicaid-funded agency-directed companion service, personal assistance service, or respite care service, as may be appropriate;
- If an individual enrolled in CD services has a lapse (meaning there is no documented use of Personal Care, Respite or Companion hours during that period) in CD services for more than 60 consecutive calendar days, the services facilitator, or the family/caregiver functioning as the services facilitator must notify the support coordinator so that CD service may be discontinued, and the option afforded to the individual to change to agency-directed service as long as the individual still qualifies for the service. The individual cannot be his/her own SF.

Service Units and Limits

The SF may not be the individual enrolled in the waiver; a direct service provider; the individual's spouse; a parent or legal guardian of the individual who is a minor child; or the EOR who is employing the assistant or companion;

The SF must document the individual's back-up plan in case the CD employee does not report to work as expected or terminates employment without notice;

Should a CD employee not report or work or terminate employment without notice, the SF, upon the individual's or EOR's request, may provide management training to ensure that the EOR is able to recruit and employ a new CD employee.

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Service Documentation and Requirements

The services facilitator must maintain a record of each individual containing elements as set out in this section. The services facilitator's record about the individual must contain:

- 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 his responsibility for the accuracy and timeliness of the assistant's or companion's timesheets;
- All documents signed by the individual enrolled in the waiver or the EOR, as appropriate, that acknowledge their legal responsibilities as the employer;
- All contacts and consultations documented in the individual's medical record. Failure to document such contacts and consultations will be subject to a DMAS recovery of payments made;
- All copies of the consumer-directed plan for support, all supporting documentation related to consumer-directed services, and DMAS-225 (Medicaid Long-Term Care Communication Form);
- A completed copy of the standard, assessment form (DBHDS-approved developmental assessment or SIS® assessment form, depending on the individual's age);
- Services facilitation notes recorded and dated at the time of service delivery. The written summary of visits must include at minimum:
 - Discussion with the individual and EOR or individual's family/caregiver, as appropriate, as to whether the particular consumer-directed service is adequate to meet the individual's needs;
 - Any suspected abuse, neglect, or exploitation and to whom it was reported;
 - Any special tasks performed by the CD employee and the employee's qualifications to perform these tasks;
 - The individual's and EOR's or individual's family/caregiver's, as appropriate, satisfaction with the CD employee's service;
 - Any hospitalization or change in medical condition, functioning, or cognitive status; and

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- The presence or absence of the assistant in the home during the services facilitator's visit.
- All correspondence to the individual and EOR, as appropriate, to others concerning the individual, and to the support coordinator, DMAS, and DBHDS.
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
 - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;
 - Information about any newly identified safety risks;
 - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
 - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
 - Any significant events.
- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within calendar days following the end of each ISP plan quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the SF by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
 - Contacts made with the individual's family/caregiver, physicians, providers, and all professionals concerning the individual.
- Service facilitation records must be provided to DMAS or DBHDS upon request.