

Provider Manual Title: Developmental Disabilities Waivers (BI, FIS, CL)

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Chapter II: Provider Participation Requirements

CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PROVIDER ENROLLMENT

A participating provider is a person or organization who has a current, signed participation agreement with DMAS.

Effective April 4, 2022 all newly enrolling providers seeking to participate with Medicaid managed care or fee-for-service (FFS) must be screened and enrolled with DMAS.

DMAS's online provider enrollment process may be accessed through the Provider Enrollment link located on the DMAS Medicaid Enterprise System (MES) Provider Resources site at <https://vamedicaid.dmas.virginia.gov/provider>.

1. As a part of the enrollment process, providers must complete a Participation Agreement applicable to their provider type. In the case of a group practice, hospital, or other agency or institution, the authorized agent of the provider institution must sign the agreement. For group practice, hospital, or other agency or institution, DMAS must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

2. A National Provider Identifier (NPI) number must be obtained from the National Plan and Provider Enumeration System (NPPES) and provided with the enrollment application. An enrolled provider's NPI is used by MES to manage provider information across functions. For example, this number must be used on all claims submitted to DMAS.

Provider NPIs may be disclosed to other Covered Healthcare Entities pursuant to Centers for Medicaid and Medicare Services (CMS) regulations requiring the disclosure of NPIs as a part of HIPAA-compliant standard transactions. (Please reference the Healthcare Information Portability and Accountability Act (HIPAA) of 1996.)

3. Providers must have an active license from the relevant state licensing authority and provide proof of licensure during the enrollment process.

4. The provider must be successfully screened according to the requirements detailed in the next section (titled "Provider Screening Requirements").

5. Providers may be denied enrollment for any of the following reasons:

- failing to submit any of the requested information;
- conviction of a felony;
- conviction of health care fraud;
- if there are past licensure actions or actions related to privileges, enrollments, educational tenure, board certifications, authorizations, participation in health care programs, malpractice actions, liability actions, or other actions or

information indicating that the individual may pose a risk to the health, safety or welfare of Medicaid members.

6. Providers who are located in another state but within 50 miles of the Virginia border may be permitted to enroll if all other qualifications are met, but are required to submit claim documentation to DMAS during the enrollment process.

7. Providers will be notified of the enrollment decision by email notice or letter mailed to the address entered into the provider enrollment portal. For denied applications, information about filing an appeal is included in the notice or letter.

8. The enrollment effective date will begin the 1st day of the month in which the application is received, unless a retroactive effective date is approved for documented extenuating circumstances.

If you have any questions regarding the enrollment process, please email Provider Enrollment Services at VAMedicaidProviderEnrollment@gainwelltechnologies.com or phone toll free 1-888-829-5373 or local 1-804-270-5105.

PARTICIPATION IN MANAGED CARE AND FEE FOR SERVICE (FFS)

Any provider of services must be enrolled with DMAS prior to billing for services rendered to eligible individuals, including individuals enrolled in either FFS or Medicaid managed care.

Most individuals who are eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS) benefits are enrolled with one of the Department of Medical Assistance Services' (DMAS') contracted Managed Care Organizations (MCOs) and receive services from the MCO's network of providers. All participating providers must confirm the individual's MCO enrollment status prior to rendering services. The MCO may require a referral, service authorization or other action prior to the start of services. All providers are responsible for adhering to state and federal requirements, their MCO provider contract(s) (as applicable), and the applicable DMAS provider manual. For providers to participate with one of DMAS' contracted MCOs, they must also become a participating provider in the MCO's network.

Please visit the DMAS website at <https://vamedicaid.dmas.virginia.gov/provider> for more information on participation with the Medicaid FFS and managed care programs

Carved-Out Services

Regardless of an individual's MCO enrollment, some services are "carved-out" of the managed care program and are paid directly by DMAS using FFS methodology. Providers must follow the FFS rules in these instances.

Individuals who receive services under one of the three 1915(c) Developmental Disabilities Home and Community-Based Services (HCBS) Waivers, including the Building Independence, Community Living, and Family and Individual Supports Waivers, are enrolled in managed care for their non-waiver services (e.g., acute, behavioral health, pharmacy, and non-waiver transportation services). The individual's waiver services benefits are carved-out and managed directly by DMAS.

PROVIDER SCREENING REQUIREMENTS

The 21st Century Cures Act (Cures Act) 114 P.P.255 requires all states to screen Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) upon enrollment. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate", or "high."

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations and State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

In addition to the screening requirements applicable to the limited risk provider category listed above, unannounced pre-and/or post-enrollment site visits apply to moderate risk providers. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submit fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation, and when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice.

CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid program or Medicare or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination may be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Screening

Prior to enrollment in DMAS, providers with a primary servicing address located outside of the Virginia border must have a site visit conducted by either their state’s Medicaid program or by CMS due to their provider risk-level. Pursuant to 42 CFR 455 Subpart E, an application will be pended for proof of this information if it is received by DMAS prior to the completion of the site visit.

Revalidation Requirements

All participating providers are required to revalidate at least every 5 years. Providers are notified in writing of their revalidation due date and of any new or revised provider screening requirements. (Providers will indicate their preferred mode of notification, i.e., email or USPS, at the time of enrollment.) DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements if a provider is enrolled as a Medicare provider at the time of revalidation.

ORDERING, REFERRING, AND PRESCRIBING (ORP) PROVIDERS

42 CFR 455.410(b) states that state Medicaid agencies must require all ordering, or referring, and prescribing physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ORP providers to enroll to meet new program integrity requirements designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid members originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. There is one exception: the provider enrollment requirements do not apply to physicians who order or refer services for a Medicaid member in a risk-based managed care plan.

If a provider does not participate with Virginia Medicaid currently but may order, refer, or prescribe to Medicaid members, they must be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Virginia Medicaid Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking waiver services and medical care from any institution, pharmacy, provider, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject supports, medical care and treatment.
- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals in amounts not to exceed the provider's usual and customary charges to the general public.

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- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill an eligible individual for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.
 - Accept assignment of Medicare benefits for eligible individuals.
 - Use DMAS-designated billing forms to submit claims.
 - Maintain and retain business and professional records sufficient to fully and accurately document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than six years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.
 - Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
 - As requested by DMAS, disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to eligible individuals.
 - Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

In order to comply with Federal Regulations and Virginia Medicaid Program policy, providers are required to ensure that Medicaid is not paying for any items or services

furnished, ordered, or prescribed by individuals or entities that have been excluded from participation in any state Medicaid Program or Medicare.

Payments cannot be made for items or services furnished, ordered, or prescribed by an excluded provider or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the payment itself is made to another provider, practitioner, or supplier that is not excluded, but is affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by the Virginia Medicaid Program may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to meet Federal and Virginia Medicaid program integrity requirements:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in Medicaid or Medicare. (Go to <https://oig.hhs.gov/exclusions/>)
- Search the Health and Human Services Office of the Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs.
- Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions 600 E. Broad St, Suite 1300
Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmass.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provisions for individuals with disabilities in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the basis of race, color, religion, sex, or national origin.

UTILIZATION OF INSURANCE BENEFITS

Virginia Medicaid is a "payer of last resort" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or, third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- Workers' Compensation - No payments shall be made for a patient covered by Workers' Compensation.
- Other Health Insurance - When an eligible individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), the Virginia Medicaid Program requires that these benefits be used first. Supplementation shall be made by the Virginia Medicaid Program when necessary, but the combined total payment from all insurance, shall not exceed the amount payable under Medicaid had there been no other insurance.
- Liability Insurance for Accidental Injuries - DMAS will seek repayment from any settlements or judgments in favor of eligible individuals who receive medical care as the result of the negligence of another. DMAS should be notified promptly if an

eligible individual is treated as the result of an accident, DMAS should be notified promptly so action can be initiated to establish a lien as set forth in the Code of Virginia §8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. The form can also be sent electronically to TPLcasualty@dmas.virginia.gov

DOCUMENTATION REQUIREMENTS

The Virginia Medicaid Program provider participation agreement requires that medical records fully disclose the extent of services provided to all Medicaid members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and the description of the services rendered must be clear. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery.

ELECTRONIC SIGNATURES

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of the electronic signatures for clinical documentation purposes shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers shall have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use electronic signatures shall sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use shall be maintained and available at the provider's location.

Additionally, the use of electronic signatures shall be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These

requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records.

TERMINATION OF PROVIDER PARTICIPATION

The provider participation agreement is time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to DMAS 30 days prior to the effective date. The written notification should be sent to the following address:

DMAS Provider Enrollment Services
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider's participation agreement. DMAS must provide written notification 30 days prior to the termination's effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Pursuant to §32.1-325 (D) of the Code of Virginia, the DMAS Director of Medical Assistance Services is authorized to:

Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

Appeals of Provider Termination or Enrollment Denial: A provider has the right to appeal in any case in which a Virginia Medicaid Program provider agreement or contract is terminated or denied pursuant to Virginia Code §32.1-325(D). The provider may appeal the decision in accordance with the Administrative Process Act (Code of Virginia §2.2-4000 et seq.) and the Provider Appeals regulations (12 VAC 30-20-500 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual’s behalf. The provider appeals process is described below. The client appeals process is described in Chapter III.

PROVIDER APPEALS

Definitions

Administrative Dismissal –the dismissal of a provider appeal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings.

Adverse Action – means, for services that have already been rendered, the termination, suspension, or reduction in covered benefits or the denial or retraction, in whole or in part, of payment for a service. An adverse action may also include the denial or termination of enrollment as a DMAS participating provider.

Appeal – means:

1. A request made by an MCO provider (in-network or out-of-network) to review the MCO’s reconsideration decision of an adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a DMAS-enrolled provider exhausts the MCO’s reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid’s provider appeal regulations at 12 VAC 30-20-500 *et seq.*; or

2. For fee-for-service (“FFS”) services, a request made by a provider to review DMAS’ adverse action or a DMAS Contractor’s reconsideration decision of an adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid’s provider appeal regulations at 12 VAC 30-20-500 *et seq.*

Reconsideration – means a provider’s reconsideration request of an adverse action.

The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers. Many adverse actions require a provider to request reconsideration with DMAS or the DMAS Contractor before appealing to the DMAS Appeals Division. Read the denial notice carefully to determine if reconsideration is required, as the reconsideration process is a pre-requisite to filing an appeal with the DMAS Appeals Division. Failure to exhaust a required reconsideration process will result in the appeal to the DMAS Appeals Division being deemed premature.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. For EAPG and ClaimCheck actions, the request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal reconsideration rights with an MCO must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO. A reconsideration may also be required by other DMAS contractors before appealing to DMAS.

For services that have been rendered and any applicable reconsideration rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et seq.*

Provider appeals to DMAS must be submitted in writing and within 30 calendar days of the provider's receipt of the DMAS adverse action or final reconsideration decision. There are two case types that have other timeframes to file appeals: (1) provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed within 15 calendar days of the provider's receipt of the DMAS adverse action; and (2) providers appealing adjustments to a cost report are required to file the informal appeal within 90 calendar days of the provider's receipt of the notice of program reimbursement.

The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the adverse action being appealed. To ensure that the appeal is efficiently processed, include: the provider's name, National Provider Identification number (NPI), recipient name(s) and Medicaid ID# *[if applicable]*, date(s) of service *[if applicable]*, claim or service authorization number *[if applicable]*, and the reason for the appeal. Also include a copy of the adverse action and a contact name, phone number, and address for appeal correspondence.

Failure to file a written notice of informal appeal within the prescribed timeframe or that does not identify the action being appealed will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at <https://www.dmas.virginia.gov/appeals/>. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at <https://www.dmas.virginia.gov/appeals/>. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
 - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - Email to appeals@dmas.virginia.gov; or
 - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's

receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et seq.* and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the

adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee must then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries must be final.

PROVIDER REQUIREMENTS – DEVELOPMENTAL DISABILITY WAIVERS

- In order to ensure compliance with CMS requirements as well as protect the privacy of those who are providing services to individuals enrolled and receiving services through the Developmental Disabilities Waivers during Quality Management Reviews, the provider must retain the following documentation and make it available upon request:
 - Verification that staff fingerprints were obtained and sent (copy of what was sent to include a date)
 - Verification that the results were received (letter from company indicating the results)
 - Verification, if there was evidence of a conviction, that the results were reviewed and there is a statement indicating the results were reviewed to determine if barrier crimes were or were not noted. The statement should be signed and dated with the printed name and title included)
- Perform criminal history record checks for barrier crimes in accordance with applicable licensure requirements at §§ 37.2-416, 37.2-506, and 37.2-600 37.2-607 of the Code of Virginia, as applicable. If the individual enrolled in the waiver is a minor child, also perform a search of the VDSS Child Protective Services Central Registry. The provider will not be compensated for services provided to the individual enrolled in the waiver effective on the date and afterwards that any of these records checks verifies that the staff person providing services was ineligible to do so pursuant to the applicable statute.

For consumer-directed (CD) services, the CD attendant must submit to a criminal history records check obtained by the fiscal employer agent within 30 days of employment. If the individual enrolled in the waiver is a minor child, the CD attendant must also submit to a search within the same 30 days of employment of the VDSS Child Protective Services Central Registry. The CD attendant will not be compensated for services provided to the waiver individual effective the date on which the employer of record learned, or should have learned, that the record check verifies that the CD attendant has been convicted of barrier crimes pursuant to § 37.2-416 of the Code of Virginia or if the CD attendant has a founded complaint confirmed by the VDSS Child Protective Services Central Registry (if applicable).

- The DMAS-designated fiscal employer agent will require the CD employee to notify the employer of record of all convictions occurring subsequent to the initial record check. CD employees who refuse to consent to criminal background checks and VDSS Child Protective Services Central Registry checks will not be eligible for Medicaid reimbursement. The CD employer of record will require CD employees to notify the employer of record of all convictions occurring subsequent to the initial record check.

The CD employer of record will require CD employees to notify the employer of record of all convictions occurring subsequent to the initial record check.

- Accept referrals for services only when staff is available to initiate services within 30 calendar days of the referral and perform such services on an ongoing basis;
- Accept training on Crisis Education and Prevention Plans (CEPPs) by DBHDS, or its contractor, based on individual needs.
- For those providers licensed by DBHDS, follow DBHDS procedures to identify and report to DBHDS those individuals who are at high risk due to medical or behavioral needs or other factors that lead to a supports need level of medical (M) or behavioral (B) in tier 4. Participate in the completion of Quality Service Reviews conducted by DBHDS or its contractor.
- Permit Community Service Board support coordinators and case managers access to the premises at any time to see individuals in service settings and allow full access to the individual's records on site. Providers may not deny access to records or refuse entry to the premises.
- Provide services and supports for individuals in accordance with the Individual Support Plan (ISP) and in full compliance with 42 CFR 441.301, which provides for person-centered planning and other requirements for home and community-based settings including the additional requirements for provider-owned and controlled residential settings (see "Home and Community Based Settings

Requirements” later in this chapter); Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements;

- Use Medicaid program-designated billing forms as per chapter 5 (DD manual provider billing) for submission of claims for reimbursement;
- Develop a plan for supports that includes at a minimum for each individual they support:
 - 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; and
 - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations (12VAC35-115) and the requirements of 42 CFR 441.301.
- Prepare and maintain unique person-centered progress note written documentation in each individual's record about the individual's responses to services and rendered supports and of specific circumstances that prevented provision of the scheduled service, should that occur. Such documentation should be written, signed, and dated on the day the described supports were provided. However, documentation that occurs after the date services were provided must be dated for the date the entry is recorded and the date of actual supports delivery is to be noted in the body of the note. In instances when the individual does not

communicate through words, the provider must note his observations about the individual's condition and observable responses, if any, at the time of service delivery.

- Examples of unacceptable person-centered progress note written documentation include:
 - Standardized or formulaic notes;
 - Notes copied from previous service dates and simply re-dated;
 - Notes that are not signed and dated by staff who deliver the service, with the date services were rendered; and
 - Notes that do not document the individual's unique opinions or observed responses to supports;
- If providers are utilizing electronic signatures for documentation, then the signature must be accompanied by a digitally encoded time and date stamp. This is to assist in determining non-repudiation of the signature.
- Maintain an attendance log or similar document that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific timeframe for services with a unit of service shorter than one day) for each service type except for one-time services such as assistive technology, environmental modifications, transition services, individual and family caregiver training, electronic home-based supports, services facilitation, and personal emergency response system support, where initial documentation to support claims will suffice.
- Document and maintain written semi-annual supervision notes for each Direct Support Professional (DSP) that are signed by the supervisor. Additionally,
 - For DBHDS-licensed entities, the provider must provide ongoing supervision of staff consistent with the requirements of 12VAC35-105.
 - For providers who are licensed by VDH or have accreditation from a CMS-recognized organization to be a personal care or respite care provider, they must provide ongoing supervision of staff consistent with those regulatory requirements.
- All facilities covered by § 1616(e) of the Social Security Act in which home- and community-based services will be provided must comply with applicable standards that meet the requirements for board and care facilities. Health and safety standards will be monitored through the DBHDS' licensure standards, 12 VAC 35-102-10 et seq. or through DSS approved standards for adult foster care providers and licensure standards 22 VAC 40-70-10 et seq.;
- Refrain from engaging in any type of direct marketing activities to Medicaid individuals or their families/caregivers. "Direct marketing" means (i) conducting directly or indirectly door-to-door, telephonic, or other cold call marketing of

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

- Providers must ensure that staff providing waiver services read and write English to the degree required to create and maintain the required documentation;
- Report suspected abuse or neglect immediately at first knowledge to the local Department for Aging and Rehabilitative Services, adult protective services agency or the local department of social services, child protective services agency; to DMAS or its designee; and to the DBHDS Office of Human Rights, if applicable pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia when the participating provider knows or suspects that an individual receiving home and community-based waiver services is being abused, neglected, or exploited;
- In accordance with 12VAC30-122-120 providers of services under any of the DD Waivers may not be parents or guardians of individuals enrolled in the waiver who are minor children, or in the case of an adult enrolled in the waiver, the adult individual's spouse. Payment will not be made for services furnished by other family members who are living under the same roof as the individual receiving services unless there is objective, written documentation, as defined in this subsection, as to why there are no other providers available to provide the care. Such other family members, if approved to provide services for the purpose of receiving Medicaid reimbursement, must meet the same provider requirements as all other licensed provider staff or consumer-directed employees. "Objective, written documentation" means documentation that demonstrates there are no persons available to provide supports to the individual other than the unpaid family/caregiver who lives in the home with the individual. Examples of such documentation may be (i) copies of advertisements showing efforts to hire; (ii) copies of interview notes; (iii) documentation indicating high turnover in consumer-directed assistants who provide, via the consumer-directed model of services, personal assistance services, companion services, respite services, or any combination of these three services; (iv) documentation supporting special medical or behavioral needs; or (v) documentation indicating that language is a factor in service delivery. The service provider must provide such documentation as is necessary or requested by DBDHS for service authorization;

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- Providers will not be reimbursed while the individual enrolled in a waiver is receiving inpatient services in an acute care hospital, nursing facility, rehabilitation facility, ICF/IID, or any other type of facility;
 - In accordance with 42CFR 431.52, providers will be reimbursed when providing services to an individual enrolled in a waiver who is temporarily located or traveling outside the state of Virginia (for example, while on vacation) so long as the following criteria are met:
 - The individual maintains a permanent residence in Virginia.
 - Case management or support coordination face-to-face visits occur according to schedule and annual PC ISP meetings occur in Virginia.
 - The individual can be safely served in the out of state location including administration of medication.
 - Travel occurs within the United States or US Territories.
 - The waiver will not pay for travel expenses for the individual or individual's travel companions or for paid or non-paid caregivers.
 - Providers with a history of noncompliance, which may include (i) multiple records with citations of failure to comply with regulations or (ii) multiple citations related to health and welfare for one support plan, or (iii) citation by either DMAS or DBHDS in key identified areas, resulting in a corrective action plan or citation will be required to undergo mandatory training and technical assistance in the specific areas of noncompliance as part of a corrective action plan. These areas of noncompliance may include but are not limited to health, safety, or failure to address the identified needs of the individual. Failure to comply with any areas in the corrective action plan will result in referral to DMAS Program Integrity and initiation of proceedings related to termination of the provider Medicaid participation agreement.
 - Required training and technical assistance will be referred to as Mandatory Provider Remediation (MPR).
 - MPR includes a team from DMAS and DBHDS to provide technical assistance and training for the participating provider. DMAS and DBHDS will provide a corrective action plan to the provider. The provider must complete all items on their corrective action plan. DMAS shall make the final determination for any provider who is in the MPR process.
 - DMAS and DBHDS may refer any provider for MPR who has demonstrated continued noncompliance with regulations or previously approved corrective action plans.
 - Key identified areas of concern can include but are not limited to the following:
 - Missing or inadequate progress notes
 - Inadequate or missing Part V's or ISP's

Inadequate or unclear support instructions.

- Providers must ensure that all employees or contractors without clinical licenses who will be responsible for medication administration demonstrate competency of this set of skills under direct observation prior to performing this task without direct supervision.

- DBHDS-licensed providers must ensure all employees or contractors who will be responsible for performing de-escalation and/or behavioral interventions demonstrate competency of this set of skills under direct observation prior to performing these tasks with any individual receiving services

DEVELOPMENTAL DISABILITY WAIVER SERVICES

In addition to Targeted ID or DD Case Management that is provided to all DD Waiver individuals, the DD Waivers offer the following services:

- Assistive Technology;
- Benefits Planning;
- Center-based Crisis;
- Community-based Crisis;
- Community Coaching;
- Community Engagement;
- Community Guide;
- Companion (agency-directed and consumer-directed);
- Crisis Support Services;
- Group Day;
- Electronic Home-Based Supports;
- Environmental Modifications;
- Group Home Residential;
- Independent Living Supports;
- Individual and Family/Caregiver Training;
- In-home Supports;
- Peer Mentor Supports
- Personal Assistance (agency-directed and consumer-directed);
- Personal Emergency Response Systems (PERS);
- Private Duty Nursing
- Respite (agency-directed and consumer-directed);
- Service Facilitation;
- Shared Living;
- Skilled Nursing;
- Sponsored Residential;
- Supported Employment - Group and Individual;
- Supported Living Residential;
- Therapeutic Consultation;
- Transition Services; and
- Workplace Assistance.

INDIVIDUAL RIGHTS/RESPONSIBILITIES

The provider must have a written statement of individual rights, which clearly states the responsibilities of both the provider and the individual in the provision of services. This statement of individual rights must be signed by the individual and the provider representative at the time services are initiated. This statement must be maintained in the individual's file, and a copy must be given to the individual. The statement of individual rights must include the following:

- The provider's responsibility to notify the individual in writing of any action taken which affects the individual's services;
- The provider's responsibility to render supports according to acceptable standards of care;
- The provider's procedures for patient pay collection;
- The individual's obligation for patient pay, if applicable;
- The provider's responsibility to make a good faith effort to provide supports according to the Individual Support Plan and to notify the individual when unable to provide supports;
- The provider, or Services Facilitator in the case of consumer-directed (CD) services, of Personal Assistance (agency-directed (AD) & CD), Respite (AD & CD), Companion (AD & CD), In-home Supports, and Shared Living must inform the individual of his or her responsibility to have a back-up plan for times when the provider is unable to secure coverage and to identify which staff the individual should contact regarding schedule changes;
- The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the supports rendered, and to routinely check with the individual about his or her satisfaction with the supports being rendered; and
- The individual's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.
- The individual has a right to accept or decline services.
- The individual has a right to choose their provider.

CORE COMPETENCY REQUIREMENTS

Direct Support Professionals (DSPs) and their supervisors who provide services and supports for people with developmental disabilities (DD) are required to complete an orientation training process. This process is designed to increase the quality of services, build skills and confidence among workers, and enhance the supervisor-DSP relationship.

Any agency employee, regardless of credentials, who provides Medicaid Waiver reimbursable support as a DSP (as defined under 12VAC30-122-20), must complete the DSP orientation training process. Inclusion of any such support in a job description or similar agency expectation, establishes a role that is subject to these requirements. This process also applies to supervisors who oversee the work of DSPs. Providers may elect to employ agency trainers in delivering training content, but the use of a trainer does not supplant conversations between DSPs and supervisors about the content of the training or the application of that content within the provider setting.

This process does not apply to professional staff who provide consultative or specialized medical and behavioral support, such as Therapeutic Consultation, Skilled Nursing, and Private Duty Nursing unless these staff are acting in the capacity of a DSP or DSP Supervisor. This process is not required for Consumer-Directed Services or Services Facilitators.

AGENCY TYPES AND SERVICES

Agencies providing direct support to individuals on the Developmental Disabilities' waivers are required to complete the DSP Orientation training. This includes both non-DBHDS licensed providers (such as Home Care Organizations licensed by the Virginia Department of Health and Employment Services Organizations providing DD Waiver services) in addition to DBHDS- licensed providers.

These requirements apply to all providers of the following services:

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- Agency-Directed Personal Assistance
 - Agency-Directed Companion
 - Agency-Directed Respite
 - Center-based Crisis Services
 - Community-based Crisis Services
 - Crisis Support Services
 - Community Engagement
 - Community Coaching
 - Group Day Services
 - Group Home Residential
 - Independent Living Support Services
 - Individual and Group Supported Employment
 - In-Home Support Services
 - Sponsored Residential
 - Supported Living Residential
 - Workplace Assistance

TRAINING, TESTING, AND ASSURANCES REQUIREMENTS

Providers of the services listed above must assure that DSPs and their supervisors have received training in:

- The characteristics of developmental disabilities and Virginia's DD Waivers,
- Person-centeredness, positive behavioral supports, effective communication,
- Health risks and the appropriate interventions, and
- Best practices in the support of individuals with developmental disabilities.

Health risks include at a minimum: choking, skin care (pressure sores, skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation and bowel obstruction, change of mental status, sepsis, seizures, and early warning signs of such risks, and how to avoid such risks. Best practices include at a minimum: the concepts of dignity of risk, self-determination, community integration and social inclusion (e.g., building and maintaining positive relationships, being active and productive in society, empowerment, advocacy, rights and choice, and safety in the home and community).

This training requirement can be accomplished through the DBHDS 2016 Orientation Training Materials available online through the following website: <https://dsporientation.partnership.vcu.edu/>

Direct Support Professionals (DSPs) and DSP supervisors must pass a DBHDS-approved objective, standardized test covering the topics referenced above prior to providing direct, reimbursable services in the absence of other qualified staff who have passed the knowledge-based test and who document the provision of supports for reimbursement purposes. DSPs and supervisors must pass the written test with a score of at least 80%. All supervisors/trainers who will be preparing DSPs to pass the test and/or

meet competencies, must complete the supervisors' training online and pass the accompanying test with a score of at least 80% prior to orienting new DSPs to provide services under the DD Waivers.

DSP supervisors in both DBHDS-licensed and non-DBHDS-licensed agencies must complete online training and testing through the Commonwealth of Virginia Learning Center (COVLC). The supervisory training can be located in the COVLC by searching with the key word "DSP." More information can be found at the DBHDS website: <https://dbhds.virginia.gov/developmental-services/provider-network-supports/ctp-pd/ctp-required-training/>

A signed assurance document confirms the receipt of instruction in the required training topics. Assurance documents are specific to DSP/DSP Supervisor role. There are two versions and DSPs and DSP supervisors complete the version that matches their role within the organization. These assurance documents are available online at: <https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section9998/>

Evidence of completed core competency training, a copy of the DSP completed test, the DBHDS-issued certificate of completion for supervisors, and documentation of assurances (DMAS Form P242a and P245a as applicable), must be retained in the provider's record of each applicable staff member and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. In accordance with 12VAC30-122-180, the following waiver providers must ensure that DSPs and DSP supervisors, including relief and contracted staff, complete competency observation and the competency checklist within 180 days from date of hire:

- Agency-directed personal assistance service,
- Agency-directed companion service,
- Agency-directed respite service,
- Center-based crisis support service,
- Community-based crisis support service,
- Community engagement service,
- Community coaching service,
- Crisis support service,
- Group day service,
- Group home residential service,
- Independent living service,
- In-home support service,
- Sponsored residential service,
- Support living residential service, and
- Workplace assistance service.

From the 180 days of date of hire, DMAS will not reimburse for those services provided by DSPs or DSP supervisors who have failed to pass the orientation test.

DSPs who move employment from one agency to another and have documentation of having completed training and passed the DSP Orientation Manual Test at their prior employer do not have to be retrained, although the new agency should still discuss the values and concepts as they pertain to their agency's policies with the new employee. The new provider should obtain a copy of the DSP's scored test or supervisor's VLC certificate and assurance and keep it on file.

Certified Employment Support Professional (CESP) and Association of Community Rehabilitation Educators (ACRE) certifications may be used in lieu of competency requirements for supported employment staff in the Medicaid Community Living, Family and Individual Support and Building Independence Waiver programs. Furthermore, providers that are Department for the Aging and Rehabilitative Services vendors that hold a national three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) will be deemed qualified to meet employment staff competency requirements, provided the provider submits the results from their CARF surveys including recommendations received to the Department of Behavioral Health and Developmental Services so that the agency can verify that there are no recommendations for the standards that address staff competency.

Observed Competency Requirements

Please refer to instructions as per DMAS form P241a. If at any time a DSP or DSP Supervisor is found to be deficient in any competency area, the provider must document actions taken and the date that restoration of ability is confirmed pursuant to 12VAC30-122-180. Agencies with DSPs or DSP supervisors who have failed to pass the orientation test or demonstrate competencies as required will be referred to DMAS Program Integrity for consideration of additional actions.

Advanced Competency Requirements for DBHDS-Licensed Providers Supporting People with Complex Health Needs, Behavioral Support Needs, and/or Autism at SIS® Tier Four

DBHDS-licensed providers must also ensure that DSPs and DSP supervisors supporting individuals identified as having the most intensive needs, as determined by assignment to SIS® tier four based on a completed Supports Intensity Scale® assessment, must receive training specific to the individuals' needs and levels.

Advanced competencies are required for DSPs and DSP supervisors who support individuals at SIS® tier four who have intensive health needs, behavioral support needs, and/or a diagnosis of autism. Individuals who require a higher level of support

due to risk in one or more of these areas must only be supported by DSPs and DSP supervisors who demonstrate these competencies within 180 days of hire or within 180 days of initiating services to an individual with related support needs. **It is required that all staff within a single service setting meet the required competencies within the required timeframes based on the needs of all individuals supported in that setting.** The need for advanced competencies is established through the identification of one or more of these factors in a current assessment and/or the Individual Support Plan (ISP):

Criteria for Requiring Advanced Competencies at SIS® Tier Four

- | | |
|------------|--|
| Health | The presence of a complex health condition that necessitates specific supports and instructions indicates that Health Competencies (DMAS P244a) must be met. |
| Autism | A diagnosis of autism indicates that Autism Competencies (DMAS P201a) must be met. |
| Behavioral | The need for behavioral supports either in the ISP or in a formal behavioral plan indicates that Behavioral Supports Competencies (DMAS P240a) must be met. |

Providers must identify and implement or attend training that relates to all three advanced competency areas as applicable. Advanced competency training may be accessed through a variety of means as long as it is nationally recognized or developed or approved by a qualified professional in each competency area. Qualified professionals who can develop or approve training include:

Qualified Professionals for Advanced Competency Training Content

- | | |
|------------|---|
| Health | A physician, nurse practitioner, psychiatric nurse practitioner, or registered nurse (RN) |
| Autism | A psychiatrist; a psychologist; psychiatric nurse practitioner; a Licensed Professional Counselor (LPC); a Licensed Clinical Social Worker (LCSW); a Psychiatric Clinical Nurse Specialist, or a Certified Autism Specialist (CAS), an Occupational Therapist (OL), a Speech-Language Pathologist (SLP), a Licensed Behavior Analyst (LBA), or a Licensed Assistant Behavior Analyst (LABA) |
| Behavioral | A psychiatrist; a psychologist; psychiatric nurse practitioner; a Licensed Professional Counselor (LPC); a Licensed Clinical Social Worker (LCSW); a Psychiatric Clinical Nurse Specialist, Positive Behavioral Support Facilitator (PBSF), a Licensed Behavior Analyst (LBA), or a Licensed Assistant Behavior Analyst (LABA) |

The following topics must be included in training provided to DSPs and their supervisors when supporting individuals at SIS® tier four, where applicable:

Required Topics for Advanced Competency Training Content

Health Confidentiality; professional collaboration; communicating health information; documenting health information; relationship between physical and mental health; common risk factors for DD-related health conditions; universal precaution procedures; performing delegated tasks; supporting Virginia's identified risks for people with DD including: skin care (pressure sores; skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation & bowel obstruction, sepsis, and seizures; providing direct care to individuals with complex health care needs (e.g. ADL's, positioning, care of Durable Medical Equipment, and specialized supervision with appropriate responses to health parameters set by the health professional

Autism General characteristics of autism; dual diagnosis; environmental modifications/assessments; communication supports and strategies; social skills, peer interactions, and friendship; sensory integration; life span supports

Behavioral Ethical practices (practicing within scope); function and purpose of behavior; replacement behavior training; positive behavior support; behavioral prevention; dual diagnosis; data collection (goal and purpose); ruling out medical concerns for behavior

Evidence of completed advanced core competency training is documented on the assurance forms (DMAS Form P242a or P245a) completed by DSPs and DSP supervisors. The director of the provider agency or designee must complete the advanced core competencies checklist(s) for supervisors and DSP supervisors must complete checklists for DSPs they supervise. In instances where the director is also a supervisor or providing direct support, it is recommended that another supervisor not directly supervised by the director observe for competencies and sign the competencies checklist along with the director.

Any DSP or DSP supervisor who does not demonstrate proficiency with the required competencies within the initial 180 days from hire (or within 180 days of beginning to support a person with related needs, as applicable), must only provide support under direct supervision, observation and guidance of qualified staff who document the provision of these supports in the person's record until proficiency is confirmed and documented by the provider. If at any time a DSP or DSP Supervisor is found to be deficient in any competency area, the provider must document actions taken and the date that restoration of ability is confirmed pursuant to 12VAC30-122-180. Agencies with DSPs or DSP supervisors who have failed to pass the orientation test or demonstrate competencies as required will be referred to DMAS Program Integrity for consideration of additional actions. "Deficient" is defined as an established pattern of inability to demonstrate one or more competency skills.

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- Upon discovery of a staff person's inability to demonstrate proficiency, the provider has seven calendar days to begin remediation of the identified skills and document the issue and the actions taken by the agency to confirm proficiency.
 - If proficiency is not reconfirmed within seven days following discovery of a second episode, occurring within three months of the staff person's inability to demonstrate proficiency, the skills being remediated must only be performed under direct supervision, observation and guidance of qualified staff who document the provision of these supports in the person's record.
 - Once proficiency with these skills have been demonstrated, the provider must maintain a signed confirmation which describes the actions taken and is completed by the DSP Supervisor for DSPs and the Agency Director or designee for DSP Supervisors and may resume billing for these related supports provided by the DSP or DSP Supervisor from that date forward.

Requirements for Annual Recertification of Training Competencies:

Providers must initiate a review of these competencies, at least annually, with sufficient time to identify and remediate any concerns. Competencies are not portable across agencies and must be confirmed at each agency within 180 days of hire and reconfirmed at least annually. Providers may align the competency process with an established employee evaluation processes to ensure ongoing requirements and performance standards are met.

A new checklist must be completed every fifth year and annual documentation must include confirmation that the DSP or supervisor continues to meet standards by demonstrating the skills and behaviors as applicable in the competency checklist(s) (P240a, P244a, p201a, as applicable). The checklist(s) must be retained in the provider record and subject to review by DBHDS for licensing compliance. These checklists are available online at:

<https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section9998/>

Documentation requirements are detailed below.

- Supervisors in non-DBHDS- licensed agencies must have:
 - Supervisor's training certificate
 - DMAS P245a assurances document
 - DMAS P241a basic DSP competencies
- DSPs in non-DBHDS-licensed agencies must have:
 - Copy of written test with 80%+ score
 - DMAS P242a assurances document
 - DMAS P241a basic DSP competencies
- Supervisors in DBHDS-licensed agencies must have:
 - Supervisor's training certificate

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- DMAS P245a assurances document
 - DMAS P241a basic DSP competencies
 - DMAS P240a, P244a and P201a (as applicable) advanced competencies based on individual needs at SIS® tier four
 - DSPs in DBHDS-licensed agencies must have:
 - Copy of written test with 80%+ score
 - DMAS P242a assurances document
 - DMAS P241a basic DSP competencies
 - DMAS P240a, P244a and P201a (as applicable) advanced competencies based on individual needs at SIS® tier four

HOME AND COMMUNITY-BASED SETTINGS REQUIREMENTS

Introduction

In June 2009, the Centers for Medicare and Medicaid Services (CMS) first announced the intent to publish regulations defining the character of home and community-based settings. CMS acknowledged that some individuals who receive Home and Community Based Services (HCBS) in a residential setting managed or operated by a service provider have experienced a provider-centered and institution-like living arrangement, instead of a person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting. CMS stated that using such settings to provide home and community-based services are contrary to the purpose of the 1915(c) waiver program.

On March 17, 2014 (CMS) issued the Home and Community Based Services (HCBS) Final Rule 42 CFR 441.301. The final rule extends to the following settings in Virginia's DD waivers: group day services, group supported employment settings, group home residential, sponsored residential settings, and supported living services.

CMS defines home and community-based settings by the nature and quality of individuals' experiences. The home and community-based settings provisions establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings are intended to maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

Person-Centered Planning

The HCBS settings regulations specify that service planning for participants in Medicaid HCBS programs under section 1915(c) of the Social Security Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals.

The regulations require that the person-centered planning process is directed by the individual with long-term support needs and may include a representative that the individual has freely chosen, as well as others chosen by the individual to contribute to the process.

Minimum elements of the person-centered ISP include that it:

- Reflects that the setting was the individual's choice and is integrated in and supportive of full access of the individual to the greater community,
- Reflects the individual's strengths and preferences,
- Reflects that clinical and support needs that have been identified through a functional needs assessment,
- Includes individually identified desired outcomes and support activities,
- Reflects the (paid/unpaid) services/supports and providers of such services/supports that will assist the individual to achieve identified goals,
- Reflects risk assessment, mitigation, and backup planning,
- Is understandable (e.g., linguistically, culturally, and disability considerate) to both the individual receiving HCBS and the individual's support system,
- Identifies the individual and/or entity responsible for monitoring the PC ISP,
- With the written, informed consent of the individual, is finalized, agreed to, and signed by all individuals/providers responsible for implementation of the PC ISP,
- Is distributed to the individual and others involved in the PC ISP,
- Includes services that afford the individual the option to self-direct,
- Prevents service duplication and/or the provision of unnecessary services/supports.

Specific Settings and Protections:

The Developmental Disabilities (DD) Home and Community-Based Services (HCBS) Waivers provide Virginians eligible for DD Waiver services the choice to receive services and supports in the community versus an institutional setting. Per federal regulations (42 CFR 441.301), individuals enrolled in an HCBS waiver are permitted specific rights. For individuals enrolled in a DD waiver and receiving one of the following DD waiver services: **group day, group supported employment, group home, sponsored residential and supportive living**, the setting must:

- Be integrated in and support full access to the greater community.

Intent: Individuals who receive HCBS have equal access to the same community resources and activities available to the greater community. Rules and practices that facilitate community access should be established. When providing HCBS, individuals should not be isolated from individuals who do not have disabilities. Providers must ensure that practices do not create an environment that is institutional in nature. This includes the ability to come and go from settings (with appropriate supports) and documentation of any limitation on this right as a modification (outlined below). Providers must support individuals in their desires to participate in the community providing opportunities for new experiences using the philosophy and practice of person-centered thinking.

- For provider owned/or operated residential settings, access to the greater community is also inclusive of having access to come and go from the home. As such, each individual must be assessed for their ability to manage an entrance door and/or a room door key. If an individual in the home wants an entrance key and there are no barriers, a key must be provided. Several types of keys are permissible, including a “Smart Lock” that has a keypad where individuals are provided the access code.
- Ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Intent: People receiving HCBS have a right to be treated with respect and dignity in all aspects of life. This includes respecting people’s likes and dislikes, talking with people in a way that makes them feel respected and heard, and assisting people with personal supports in a compassionate manner that preserves their privacy and dignity. Examples of providing services with dignity include, but are not limited to:

- Addressing individuals by their preferred names (Example: refraining from nicknames that are not preferred or calling the individual by endearments such as baby, sweetie, or honey).
- Wearing typical clothing (vs. scrubs, uniforms, or clothing items with provider agency logos) while providing supports such that the greater community is unable to distinguish that an individual is receiving paid supports.
- Providing individuals with discreet and appropriate storage areas for personal items such as incontinence supplies and personal care items.
- Knocking on an individual’s bedroom/bathroom door before entering and gaining permission for entry (unless there is an emergency).
- Maintaining a setting that is free from institutional traits and signage such as conspicuously posted memos/training for staff, staff sign in/out logs, reminders and notices for staff, and any information pertaining to the PHI/PII of an individual in the setting.
- Utilizing person-first language in verbal and written documentation and refraining from language that would be demeaning to an individual using HCBS services. Examples of outdated and demeaning language may include mental retardation, client, consumer, wheelchair bound, etc. Dignified language would include person with a disability, individual, a person’s name, person who uses a wheelchair.

- Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Intent: People retain the ability to make choices about how they spend their time in any given setting and have opportunities to participate in age-appropriate activities. Providers must engage with the individual and the team using person-centered thinking to ensure that:

- Individuals are supported in life-informed “real” choices and autonomy;
- Individuals are offered actual experiences on which they can base future choices;
- Plans are created with the appropriate balance between autonomy and safety;

Individuals’ personal preferences are made a priority. When there is a difference of opinion with a guardian or provider preference (unless for a documented health and safety reason), there should be open dialogue in order to come to agreement

- Individuals are supported and inspired to work toward their goals, dreams, and priorities.
 - Individuals’ choices regarding services and supports, and who provides them are facilitated. If an individual wishes to change their services or support, they can do so without fear of retaliation or coercion by the current service or support provider.
 - Individuals’ choices to decline activities or supports are respected. This includes staying home rather than attending day support or another activity. Individuals should be informed about any potential risks or natural consequences of their choices, and this should be documented and re-evaluated with the individual on a regular basis.
 - All settings should be providing individualized services in accordance with the PC ISP. Use of setting-wide incentives/behavioral modification does not align with person-centered supports. Any behavior modification program must be developed by an appropriate professional with documented individual agreement to the plan.
- In **addition** to the rights and qualities specified above, in provider operated settings where group home, sponsored residential and supportive living services are provided, the following conditions must be met:
 - The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of Virginia. For settings in which landlord tenant laws do not apply, there will be a lease, residency agreement, or other form of written agreement in place for each HCBS participant, and the document provides protections that address eviction processes and appeals comparable to those provided under the landlord tenant law.

Intent: Individuals have the right to know their legal protections as renters. This includes a lease or residency agreement that include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant laws. This should be a time-limited document that is renewed in a significant and understandable way with the individual. This will also include specific information regarding leaving housing and when an individual could be required to relocate. This eviction process should be explained to the individual and follow the Virginia Landlord Tenant Act.

- Each individual has privacy in their sleeping or living unit:
 - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
 - Individuals have keys to their home. This can include a physical key or key code.
 - Individuals sharing units have a choice of roommates in that setting. This is documented and re-evaluated on an ongoing basis.
 - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Intent: Individuals have the same rights as all other citizens in their homes. This requirement is intended to ensure individuals have the privacy they desire and can lock their bedroom doors if they choose. Rather than requiring an individual to share a room with a stranger, providers must have a process for individuals to choose their own roommates. This requirement is also intended to ensure that the individual's living space feels like a home to them and can be furnished or decorated as they choose. Any limitations to décor (such as having to return walls back to their original color, refraining from structural changes, etc.) must be outlined in the lease agreement.

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- Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

Intent: Individuals control their day-to-day lives the same way other community members do. This includes control over planning their own daily schedules and activities and choosing when and what they eat. This includes the ability to choose not to participate in scheduled activities.

- Individuals can have visitors of their choosing at any time.

Intent: Individuals can develop close, private, and personal relationships without having unnecessary barriers or obstacles imposed on them. HCBS federal rules require that individuals be able to have visitors at any time, without restriction, just as anyone would have in their own home or rental unit. Providers should not be screening who the individual elects to have as a visitor. This does not mean that individuals can be inconsiderate of others' rights or the need for quiet and safety in the residence. It is intended to ensure that individuals who live in residential settings have the same freedoms as other community members in relationships with visitors in their own homes. Providers can stipulate in the lease agreement how long a visitor can stay without considered being a tenant; however, these stipulations must continue to allow for overnight visitors for at least 72 hours.

- The setting is physically accessible to the individual.

Intent: For those individuals who need supports to move about the setting as they choose, providers of HCBS services must provide for adaptations for physical accessibility. All common areas of a residential setting must be accessible to the individuals in the setting. This includes all areas of the home that would be used in typical daily activities including general living spaces, kitchens, dining rooms, laundry rooms, pantry/food storage, bathrooms, and any office area within the residential setting. Adaptations for physical accessibility may include, but are not limited to:

- grab bars,
- seats in the bathroom,
- ramps for wheelchairs,
- viable exits for emergencies,
- accessible appliances to individuals (e.g., the washer/dryer are front loading for individuals who use wheelchairs),
- tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably.

Modification to Residential Rights

If an individual requires a modification to any residential specific right (except the right to physical accessibility, which cannot be modified), the provider must document the following in the ISP. In addition, the provider is responsible for all supplemental documentation as it relates to data collection.

- Identify a specific and individualized assessed need for the modification to the right.

Document the positive interventions and supports used prior to any modifications to the person-centered ISP.

- Document less intrusive methods of meeting the need that have been tried but did not work. These interventions can include past experiences from previous settings and support types but must be documented for historical information.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Provider Documentation Requirements

- Providers of services in any of the HCBS affected settings must develop a Home and Community Based Services Rights Policy. This policy must be inclusive of the following:
 - A specific outline of the rights afforded to people receiving HCBS services (including a value on community and personal interests);
 - A person-centered planning policy; and
 - Procedures for the modification of rights (in residential settings).
- Documentation (via a disclosure form) that a provider has reviewed, in a significant and understandable manner, the HCBS afforded rights to each individual receiving services upon admission into a program and annually thereafter.
- Agency policy and appropriate documentation that new employees, contractors, students, and volunteers are trained in HCBS rights upon orientation to an agency and annually thereafter.
- All documentation related to residential-specific modifications, including informed consent forms, data collection forms, regular modification reviews, and all less-intrusive attempts to support an individual rather than modify a right.

Provider resources

Additional information, reference material, and further guidance on HCBS settings provider requirements are located in the HCBS Toolkit at

<https://www.dmas.virginia.gov/for-providers/long-term-care/waivers/home-and-community-based-services-toolkit/>.

SUPPORT COORDINATION/CASE MANAGEMENT

Support Coordination for Persons with Intellectual Disability

Providers of support coordination for individuals with intellectual disability must be limited to the Community Services Boards. All CSB/BHA providers must have a current, signed provider agreement with DMAS and must directly bill DMAS for reimbursement.

The provider must meet the following criteria:

- The provider must guarantee that individuals have access to emergency services on a 24-hour basis. "Emergency services" are defined in DBHDS Licensing regulations as "unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week;"
- The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;
- The provider must have the administrative and financial management capacity to meet state and federal requirements;
- The provider must document and maintain individual records in accordance with state and federal requirements;
- The provider must submit the Individual Support Plan in an electronic format in the state DD Home and Community-Based Services (HCBS) waiver management system for service authorization and data management for individuals enrolled in any DD HCBS waiver. The provider must submit evidence of follow-up and monitoring to assess ongoing progress of the ISP, ensuring services are delivered, and health and safety is maintained to DMAS and/or DBHDS in the format specific;
- The provider must participate in activities designed to safeguard individuals' health and safety in accordance with approved DD HCBS waiver requirements and/or DBHDS licensing standards;
- The provider must participate in activities designed to assure ongoing compliance by DD HCBS waiver participants' providers of service subject to the Final Rule Settings Requirements found at 42 CFR 441.301(4) and as described in the approved Statewide Transition Plan;
- The services must be in accordance with the Virginia State Plan; and
- The provider must be licensed as a developmental disability support coordination agency by the Department of Behavioral Health and Developmental Services.

Providers may bill for intellectual disability support coordination only when the services are provided by qualified support coordinators. The support coordinator must possess a combination of intellectual disability work experience and relevant education that indicates that the incumbent, at entry level, possesses the knowledge, skills, and abilities listed in this subdivision. These must be documented in the application form or supporting documentation or observable and documented during the interview (with appropriate supporting documentation).

Knowledge of:

- The definition, and causes of intellectual disability and best practices in supporting individuals who have intellectual disability;
- Treatment modalities and intervention techniques, such as positive behavior supports, person-centered practices, independent living skills training, community inclusion/employment skills, supportive guidance, family education, crisis intervention, discharge planning, and support coordination;
- Different types of assessments and their uses in service planning;
- Individuals' civil and human rights;
- Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures, and generic community resources;
- Types of intellectual disability programs and services;
- Effective oral, written, and interpersonal communication principles and techniques;
- General principles of documentation; and
- The service planning process and the major components of an ISP.

Skills in:

- Interviewing;
- Negotiating with individuals and service providers;
- Observing and documenting an individual's behaviors;
- Identifying and documenting an individual's needs for resources, services, and other assistance;
- Identifying services within the established service system to meet the individual's needs and preferences;

- Coordinating the provision of services by diverse public and private providers, generic and natural supports;
- Using information from assessments, evaluations, observations, and interviews to develop and revise as needed individual support plans;
- Formulating, writing, and implementing individualized individual support plans to promote goal attainment and community integration for individuals with intellectual disability;
- Using information from assessment tools evaluations, observations, and interviews to develop and revise as needed individual support plans (for example to ensure the ISP is implemented appropriately, identify change in status or to determine risk of crisis/hospitalization); and
- Identifying community resources and organizations and coordinating resources and activities.

Abilities to:

- Demonstrate a positive regard for individuals and their families (e.g., treating people as individuals, allowing risk taking, avoiding stereotypes of people with intellectual disability, respecting individual and family privacy, and believing individuals can grow and contribute to their community);
- Be persistent and remain objective;
- Work as team member, maintaining effective interagency and intra-agency working relationships;
- Work independently, performing position duties under general supervision;
- Communicate effectively, verbally and in writing; and
- Establish and maintain ongoing supportive relationships.

Support Coordination for Individuals with Developmental Disabilities Other than Intellectual Disability

Providers of support coordination to individuals with developmental disabilities other than ID must be CSBs or BHAs that have current, signed provider agreements with the Department of Medical Assistance Services (DMAS) and directly bill DMAS for reimbursement. CSBs or BHAs must contract with other entities to provide support coordination.

The provider must meet the following criteria:

- The provider must guarantee that individuals have access to emergency services on a 24-hour basis. “Emergency services” are defined in DBHDS Licensing regulations as “unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week;”
- The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid;
- The provider must have the administrative and financial management capacity to meet state and federal requirements;
- The provider must document and maintain individual records in accordance with state and federal requirements; and
- The provider must submit the Individual Support Plan in an electronic format in the state DD Home and Community-Based Services (HCBS) waiver management system for service authorization and data management for individuals enrolled in any DD HCBS waiver. The provider must submit evidence of follow-up and monitoring to assess ongoing progress of the ISP, ensuring services are delivered, and health and safety is maintained to DMAS and/or DBHDS in the format specific;
- The provider must participate in activities designed to safeguard participants’ health and safety in accordance with approved DD HCBS waiver requirements and/or DBHDS licensing standards; and
- The provider must participate in activities designed to assure ongoing compliance by DD HCBS waiver participants’ providers of service subject to the Final Rule Settings Requirements found at 42 CFS 441.301(4) and as described in the approved Statewide Transition Plan.

The provider must be licensed as a developmental disability support coordination agency by the Department of Behavioral Health and Developmental Services.

Support coordinators who provide developmental disability support coordination services and were hired after September 1, 2016, must possess a minimum of a bachelor's degree in a human services field or be a registered nurse. Support coordinators hired before September 1, 2016, who do not possess a minimum of a bachelor's degree in a human services field or are not a registered nurse may continue to provide support coordination if they are employed by or contracting with an entity that had a Medicaid provider participation agreement to provide developmental disability support coordination prior to February 1, 2005, and the support coordinator has maintained employment with the provider without interruption, which must be documented in the personnel record.

Support coordinators must possess developmental disability work experience or relevant education that indicates that at entry level he/she possesses the following knowledge, skills, and abilities that are documented in the employment application form or supporting documentation or during the job interview:

Knowledge of:

- The definition and causes of developmental disability and best practices in supporting individuals who have developmental disabilities;
- Treatment modalities and intervention techniques, such as positive behavioral supports, person-centered practices, independent living skills, training, community inclusion/employment training, supportive guidance, family education, crisis intervention, discharge planning, and service coordination;
- Different types of assessments and their uses in determining the specific needs of the individual with respect to his ISP;
- Individuals' human and civil rights;
- Local service delivery systems, including support services;
- Types of programs and services that support individuals with developmental disabilities;
- Effective oral, written, and interpersonal communication principles and techniques;
- General principles of documentation; and
- The service planning process and the major components of the ISP.

Skills in:

- Interviewing;
- Negotiating with individuals and service providers;
- Observing and documenting an individual's behaviors;
- Identifying and documenting an individual's needs for resources, services, and other assistance;
- Identifying services within the established service system to meet the individual's needs and preferences;

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- Coordinating the provision of services by diverse public and private providers, generic and natural supports;
 - Analyzing and planning for the service needs of individuals with developmental disability;
 - Formulating, writing, and implementing individual-specific support plans designed to facilitate attainment of the individual's unique goals for a meaningful, quality life; and
 - Using information from assessments, evaluations, observations, and interviews to develop and revise as needed individual support plans (for example to ensure the ISP is implemented appropriately, identify change in status or to determine risk of crisis/hospitalization).

Abilities to:

- Demonstrate a positive regard for individuals and their families (e.g., allowing risk taking, avoiding stereotypes of people with developmental disabilities, respecting individual and family privacy, believing individuals can grow and contribute to their community);
- Be persistent and remain objective;
- Work as a team member, maintaining effective interagency and intra-agency working relationships;
- Work independently, performing position duties under general supervision;
- Communicate effectively, orally and in writing; and
- Establish and maintain ongoing supportive relationships.

Support coordinators must not be:

- The direct care staff person or "DSP," defined as a staff member identified by a waiver services provider that has the primary role of assisting the individual on a day-to-day basis with routine personal care needs, social support, and physical assistance in a wide range of daily living activities so that the individual can lead a self-directed life in his own community,
- The immediate supervisor of the direct care staff person,
- Otherwise related by business or organization to the direct care staff person, or
- An immediate family member of the direct care staff person.

Support coordination services must not be provided to the individual by:

- Parents, guardians, spouses, or any family living with the individual, or
- Parents, guardians, spouses, or any family employed by an organization that provides support coordination for the individual except in cases where the family member was employed by the support coordination entity prior to implementation of the DD waivers regulations effective 5/01/2021.

Support coordinators must receive supervision within the employing organization. The supervisor of the support coordinator must have one of the following:

- A master's degree in a human services field and one year of required documented experience working with individuals who have developmental disabilities;
- A registered nurse licensed in the Commonwealth, or who holds a multistate licensure privilege, and one year of documented experience working with individuals who have developmental disabilities;
- A bachelor's degree and two years of experience working with individuals who have developmental disabilities;
- A high school diploma or GED and five years of paid experience in developing, conducting, and approving assessments and ISPs as well as working with individuals who have developmental disabilities;
- A license to practice medicine or osteopathic medicine in the Commonwealth and one year of required documented experience working with individuals who have developmental disabilities; or
- Meets other requirements as set out in the Department of Behavioral Health and Developmental Disabilities licensing regulations.

Support coordinators must obtain at least one hour of documented supervision at least every 90 calendar days.

Support coordinators must complete a minimum of eight hours of training annually in one or more of a combination of areas described in the knowledge, skills, and abilities described above and must provide documentation to his/her supervisor that demonstrates that training is completed. The documentation must be maintained by the supervisor of the support coordinator in the employee's personnel file for the purposes of utilization review. This documentation must be provided to the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services upon request.

Freedom of Choice for ID and DD Support Coordination

The provision of support coordination services must not restrict an individual's free choice of providers.

- Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in the plan.
- Eligible individuals will have free choice of any qualified Medicaid provider of other medical care under the plan.
- Individuals who are eligible for or who have received the Building Independence, Community Living, and Family and Individual Supports waivers must have free choice of support coordinator as well as the providers of support coordination services within the parameters described above and as follows. At any time, an individual may make a request to change his support coordinator. For those individuals who receive ID support coordination, choice of a neighboring CSB must be given if the individual does not desire support coordination from the CSB in whose catchment area the individual resides. For those individuals who receive DD support coordination services:
 - The CSB that serves the individual will be the provider of support coordination.
 - If the individual or family decides that no choice is desired in that CSB, the CSB must afford a choice of another CSB with whom the responsible CSB has a memorandum of agreement.
- If the individual or family decides that no choice is desired in that CSB, or with another CSB, the CSB must afford a choice of a private entity with whom they have a contract that was procured through the RFP process.
- When the required support coordination services are contracted out to a private entity, the CSB/BHA must remain the responsible provider and only the CSB/BHA may bill DMAS for Medicaid reimbursement.

ADDITIONAL OPTIONS

Assistive Technology (AT)

Assistive Technology must be provided by DMAS enrolled Durable Medical Equipment (DME) providers or DMAS enrolled Community Services Boards or Behavioral Health Authorities (CSBs/BHAs) with a signed, current waiver provider agreement with DMAS to provide the AT service.

Independent assessments for the AT service must be conducted by independent professional consultants. Independent, professional consultants include, for example, speech-language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. The type of professional providing the assessment must be appropriate to the device or equipment.

Providers that supply AT service for an individual must not perform the assessment or consultation or write the specifications. Any request for a change in cost, either an increase or a decrease, requires justification and supporting documentation of medical need necessity and service authorization by DMAS or its designee. The provider must receive a copy of the professional evaluation to purchase the items recommended by the professional. If a change is necessary, then the provider must notify the assessor to ensure the changed items meet the individual's needs.

If a rehabilitation engineer or certified rehabilitation specialist is needed to combine systems not typically designed to be compatible, modify an existing device, or design/fabricate a specialized device, the plan for supports and service authorization request must include appropriate justification and explanation.

Providers may not be the spouse, parents (natural, adoptive, foster or step-parent/caregivers) or guardian of the individual receiving service.

Community Guide

Providers must have a current, signed provider participation agreement with DMAS in order to provide this service. The provider designated in the participation agreement must directly provide the service and bill DMAS for reimbursement.

General Community Guide services must be provided by persons who have successfully completed and received a certificate of completion for both The Learning Community's:

- Person-Centered Thinking training; and
- Community Connections training.

The Community Housing Guide services must be provided by persons who have successfully completed:

- The Learning Community's Person-Centered Thinking training; and
- DBHDS Independent Housing Curriculum Modules 1-3.

Electronic Home-Based Supports (EHBS)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

An EHBS service provider must be one of the following:

- A Medicaid-enrolled licensed personal care agency;
- A Medicaid-enrolled durable medical equipment provider;
- A CSB or BHA;
- A center for independent living;
- A licensed and Medicaid-enrolled home health provider;
- An EHBS manufacturer/company that has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring; or
- A PERS manufacturer/company that is Medicaid-enrolled and has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring services.

The provider of ongoing monitoring systems must provide an emergency response center with fully trained operators who are capable of:

- Receiving signals for help from an individual's equipment 24 hours a day, 365 or 366 days per year as appropriate;
- Determining whether an emergency exists; and
- Notifying the appropriate responding organization or an emergency responder that the individual needs help.

The EHBS service Provider must have a copy of the individual's back up plan in the event of emergency system failure.

The EHBS service provider must have the primary responsibility to furnish, install, maintain, test, and service the equipment, as required, to keep it fully operational. The provider must replace or repair the device within 24 hours of the individual's notification of a malfunction of the unit or device.

The EHBS service provider must properly install all equipment and must furnish all supplies necessary to ensure that the system is installed and working properly.

The EHBS service provider must install, test, and demonstrate to the individual and family/caregiver, as appropriate, the unit or device before submitting a claim to DMAS. The provider responsible for installation of devices must document the date of installation and training in use of the devices.

The provider may not be reimbursed for installation if the individual or family/caregiver self-installs the unit or device.

The provider of off-site monitoring must document each instance of action being taken on behalf of the individual. This documentation must be maintained in this provider's record for the individual and must be provided to either DMAS or DBHDS upon demand. The record must document all of the following:

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- Delivery date and installation date of the EHBS;
 - The signature of the individual or his family/caregiver, as appropriate, verifying receipt of the EHBS device;
 - Verification by a test that the EHBS 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 care provider or support coordinator/case manager; and
 - A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, support coordinator, or responder.

Environmental Modifications (EM)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

An EM service provider must be one of the following:

- A Medicaid-enrolled durable medical equipment provider; or
- A CSB or BHS.

The contractor must:

- Comply with all applicable state and local building codes;
- If used previously by the provider, have satisfactorily completed previous environmental modifications; and
- Be available for any service or repair of the environmental modifications.

As described in Chapter IV, it is possible that the services of any or all of the following four professions may be required to complete one modification:

- A Rehabilitation Engineer;
- A Certified Rehabilitation Specialist;
- A building contractor; or
- A vendor who supplies the necessary materials.

Providers may not be the spouse or parent or legal guardian of the individual receiving service.

Individual and Family/Caregiver Training (IFCT)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Individuals who provide Individual and Family/Caregiver Training must have the appropriate licensure or certification as required for the specific professional field associated with the training area, and have expertise in, experience in, or demonstrated knowledge of the training topic set out in the plan for supports.

Individual and family/caregiver training service may be provided through seminars and conferences organized by the enrolled provider entities. The service may also be provided by individual practitioners who have experience in or demonstrated knowledge of the training topics. Individual practitioners may include psychologists, teachers or educators, social workers, medical personnel, personal care providers, therapists, and providers of other services such as day and residential support services.

Qualified provider types include:

- Staff of home health agencies, community developmental disabilities service agencies, developmental disabilities residential providers, community mental health centers, public health agencies, hospitals, clinics, or other agencies or organizations; and
- Individual practitioners, including licensed or certified personnel such as RNs, LPNs, psychologists, speech-language therapists, occupational therapists, physical therapists, licensed clinical social workers, licensed behavior analysts, and persons with other education, training, or experience directly related to the specified needs of the individual as set out in the ISP.

Peer Mentor Supports

The administering agency for this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

The administering agency must be a DBHDS licensed provider of DD services, Employment Service Organization, or Center for Independent Living. The administering agency must serve as the enrolled provider and maintain the documentation of the peer mentor's qualifications, criminal background and Child Protective Registry (if service recipient is under age 18) checks, and other required documentation.

Peer Mentor Supports must be provided by an individual with a developmental disability who has lived independently in the community for at least one year and is or has been a recipient of services, including but not limited to publicly-funded housing, Medicaid waiver services, work incentives, and supported employment. "Living independently" can mean living in his/her own home or apartment, inclusive of receiving waiver supports such as In-home Supports, Independent Living Supports, Supported Living or Shared Living.

Residents of group homes or sponsored residential homes and those residing in their family homes may not be Peer Mentors.

The peer mentor must have completed DBHDS's DD Peer Mentor training curriculum and passed the accompanying test.

Transition Services

Providers must be enrolled as a Medicaid Provider for Case Management services and work with the DMAS designated agent – Consumer Directed Care Network (CDCN) to receive reimbursement for the purchase of appropriate transition goods or services on behalf of the individual.

CRISIS SUPPORT OPTIONS

Center-Based Crisis Support

Providers must have current signed participation agreements with DMAS and are required to directly provide the services and bill DMAS for Medicaid reimbursement.

Providers for adults shall be licensed by DBHDS as providers of Group Home Service-REACH (Regional Education Assessment Crisis Services Habilitation) or, for children, a residential group home- REACH for children and adolescents with co-occurring diagnosis of developmental disability and behavioral health needs.

Center-based crisis support service must be provided by a licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, certified pre-screener, QMHP, QDDP, or, for skill-building and supervising the individual in crisis, a DSP under the supervision of one of these professionals.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Community-Based Crisis Support

Providers of community-based crisis support service must have current signed participation agreements with DMAS and directly provide the service and bill DMAS for Medicaid reimbursement.

Providers must be licensed by DBHDS as providers of crisis stabilization service-REACH (Regional Education Assessment Crisis Services Habilitation). Community-based crisis support service must be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a certified pre-screener, QMHP, or QDDP.

Crisis Support Service

Providers of crisis support service must have current signed participation agreements with DMAS and must directly provide the service and bill DMAS for Medicaid reimbursement.

Crisis support service must be provided by entities licensed by DBHDS as providers of residential crisis stabilization service, or nonresidential crisis stabilization service. Providers must employ or utilize QDDPs, licensed mental health professionals, or other qualified personnel credentialed to provide clinical or behavioral interventions. For the purposes of services delivery and billing, those individuals that do not have a license or degree are considered non-professionals. Those that meet QDDP requirements or are licensed are considered professionals.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

EMPLOYMENT AND DAY OPTIONS

Benefits Planning

All providers of Benefits Planning services must maintain and adhere to current, signed participation agreements with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Eligible providers for Benefits Planning services must possess written verification that they are one of the following:

- A nationally certified SSA Community Work Incentive Coordinators (CWIC); or
- A DARS certified Work Incentive Specialist Advocate (WISA) approved vendor.

Only providers that have completed required Community Financial Empowerment and Financial Literacy training from the Consumer Financial Protection Bureau (CFPB) and Your Money, Your Goals are eligible to provide and receive payment for a completed Financial Health Assessment.

Community Coaching

Providers must be licensed by DBHDS as providers of non-center-based day support services.

Providers must have a current, signed provider participation agreement with DMAS to provide this service and directly provide the service and bill DMAS for Medicaid reimbursement.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.

The DSP providing community coaching service must not be an immediate family member of an individual receiving the community coaching service. For an individual receiving sponsored residential services, the DSP providing community coaching must not be a member of the sponsored family residing in the sponsored residential home.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Community Engagement

Providers must be licensed by DBHDS as providers of non-center-based day support services.

Providers must have a current, signed provider participation agreement with DMAS in order to provide this service. The provider designated in the participation agreement must directly provide the service and bill DMAS for reimbursement.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.

The DSP providing community engagement service must not be an immediate family member of an individual receiving community engagement services. For an individual receiving sponsored residential service, the DSP providing community engagement services must not be a member of the sponsored family residing in the sponsored residential home.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Employment and Community Transportation (ECT)

The service will be offered through an administering agency that possesses any DBHDS license to provide services to individuals with developmental disabilities, an Employment Service Organization, or a Center for Independent Living. Administering agencies must have a current, signed participation agreement with DMAS to provide these services. Providers as designated on this agreement are responsible for billing DMAS for Medicaid reimbursement.

The service may be provided by the individual's family member or legally responsible person of an individual over the age of 18, but may not be provided by a legally responsible individual such as the guardian, parent, step-parent of an individual under the age of 18 or spouse of an adult who is receiving the service.

In the case of private transportation, the administering agency is responsible for screening community persons to drive the individual to the designated location(s) according to the ISP.

The private driver must:

- Be 18 years of age or older;

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- Possess a valid driver's license;
 - Possess and maintain at a minimum:
 - A satisfactory driving record defined as no reckless driving charges within the past 24 months, and
 - Proof of general liability insurance coverage in compliance with federal and/or state statutory requirements The insurance must insure the driver or the passengers:
 - 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(s) within the Commonwealth, any other state in the United States, or Canada;
 - Subject to a limit or 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.

The administering agency is responsible for screening community persons to drive the individual to the designated location(s) according to the ISP. This includes verification of the private driver's:

- Possession of a current, valid driver's license and no reckless driving charges within the past 24 months,
- Possession of car insurance,
- Ensuring that the driver meets the minimum age requirement of age 18, and
- Completion of an attestation signed by the private driver, the individual, and the individual's guardian or authorized representative, as appropriate, that the driver has disclosed any relevant felonies and if listed on any registry. The

administering agency must ensure that the driver is not listed on the Virginia Sex Offender Registry.

Initially and annually the administering provider must verify and document that each private driver possesses a current, valid driver's license and car insurance.

Group Day Services

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers of the group day service must hold either a current day support or community-based day support license issued by DBHDS.

Providers of group day service must comply with HCBS setting requirements per 42 CFR 441.301 and as described earlier in this chapter.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing group day service meet provider training and competency requirements as specified earlier in this chapter.

Group and Individual Supported Employment

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers must be DARS-contracted providers of supported employment service. DARS must verify that these providers meet criteria to be providers through a DARS-recognized accrediting body. DARS must provide the documentation of this accreditation verification to DMAS and DBHDS upon request.

Providers must maintain their accreditation in order to continue to receive Medicaid reimbursement. Providers that lose their accreditation, regardless of the reason, are not eligible to receive Medicaid reimbursement and will have their provider agreements terminated by DMAS effective the same date as the date of the loss of accreditation. Reimbursements made to such providers after the date of the loss of the accreditation will be subject to recovery by DMAS. Providers whose accreditation is restored will be permitted to re-enroll with DMAS upon presentation of accreditation documentation and a new signed provider participation agreement.

Providers of group supported employment services must comply with HCBS setting requirements per 42 CFR 441.301 and as described earlier in this chapter.

Workplace Assistance

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers must be either:

- Licensed by DBHDS as a provider of non-center-based day support service, or
- Providers of supported employment services with DARS. DARS must verify that these providers meet criteria to be providers through a DARS-recognized accrediting body. DARS must provide the documentation of this accreditation verification to DMAS and DBHDS upon request.
 - DARS-contracted providers must maintain their accreditation in order to continue to receive Medicaid reimbursement.
 - DARS-contracted providers that lose their accreditation, regardless of the reason, must not be eligible to receive Medicaid reimbursement and must have their provider agreement terminated by DMAS. Reimbursements made to such providers after the date of the loss of the accreditation must be subject to recovery by DMAS.

Providers must ensure that staff providing these services meet provider training and competency requirements as specified earlier in this chapter. In addition, prior to seeking reimbursement for this service from DMAS, these providers must ensure that staff providing workplace assistance service have completed training regarding the principles of supported employment. The documentation of the completion of this training must be maintained by the provider and must be provided to DMAS and DBHDS upon request.

The DSP providing workplace assistance service must coordinate his service provision with the job coach, if there is one providing individual supported employment service to the individual being supported.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

MEDICAL AND BEHAVIORAL SUPPORT OPTIONS

Personal Emergency Response System (PERS)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers must be one of the following:

- A licensed home health or personal care agency,
- A durable medical equipment provider,
- A hospital, or

A PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring.

Providers may not be reimbursed for installation if the individual or family/caregiver self-installs the equipment. Providers may only be reimbursed for installation if they directly install the equipment.

Providers must comply with all applicable federal and state laws and regulations, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the service to be performed.

Private Duty Nursing

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Private duty nursing service may be provided by either:

- A licensed RN or
- A licensed LPN who is under the supervision of a licensed RN.

The licensed RN or LPN shall be employed by a DMAS-enrolled home health provider or contracted with or employed by a DBHDS-licensed day support service, respite service, or residential service provider.

Both RNs and LPNs providing private duty nursing service must have current licenses issued by the Virginia Board of Nursing or hold current multistate licensure privileges to practice nursing in the Commonwealth.

Skilled Nursing

Providers of RNs or LPNs for this service must have a current, signed participation agreement with DMAS to provide Skilled Nursing services. Providers that have a DMAS Participation Agreement to provide private duty nursing or home health services may provide DD Waivers skilled nursing services under this agreement. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers must either employ or subcontract with nurses who are currently licensed as either RNs or LPNs per the Code of Virginia or who hold a current multistate licensure privilege to practice nursing in the Commonwealth.

The following types of providers can provide skilled nursing services:

- A licensed RN or LPN, who is under the supervision of a licensed RN, employed by a DMAS- enrolled home health provider, or
- A licensed RN or LPN, who is under the supervision of a licensed RN, contracted with or employed by a DBHDS-licensed day support, respite, or residential services provider – which includes Independent Living Supports, Shared Living, Supported Living, In-Home Support Services, Sponsored Residential and Group Home Residential Services.

Providers (the licensed entity) must maintain documentation of required licenses in the appropriate employee personnel records. Such documentation must be provided to either DMAS or DBHDS upon request.

Foster care providers may not act as skilled nursing service providers for individuals for whom they provide foster care.

Therapeutic Consultation

- The following types of therapeutic consultation are reimbursable as DD waiver services when the individual consultant or the employee of an agency with a valid Participation Agreement meets the required provider standard: Psychology Consultation may only be provided by a professional who is:
 - A Psychiatrist who is licensed in the Commonwealth of Virginia;
 - A Psychologist who is licensed by the Commonwealth of Virginia;
 - A Licensed Professional Counselor (LPC) who is licensed by the Commonwealth of Virginia;
 - A Licensed Clinical Social Worker (LCSW) who is licensed by the Commonwealth of Virginia;
 - A Psychiatric Clinical Nurse Specialist who is licensed by the Commonwealth of Virginia; or
 - A Psychiatric Nurse Practitioner licensed by the Commonwealth of Virginia.
- Behavior Consultation may only be provided by a professional who:
 - Meets the above criteria to provide a psychology consultation; or
 - Is a Positive Behavioral Supports Facilitator endorsed by a recognized positive behavior supports organization; or
 - Is a licensed Behavior Analyst or a licensed Assistant Behavior Analyst.
- Speech Consultation: This service must be provided by a speech-language pathologist who is licensed by the Commonwealth of Virginia.
- Occupational Therapy Consultation: This service must be provided by an Occupational therapist who is licensed by the Commonwealth of Virginia.
- Physical Therapy Consultation: This service must be provided by a physical therapist who is licensed by the Commonwealth of Virginia.
- Therapeutic Recreation Consultation: This service must be provided by a therapeutic recreational specialist who is certified by the National Council for Therapeutic Recreation Certification.
- Rehabilitation Consultation: This service must be provided by a rehabilitation engineer or certified rehabilitation specialist.

RESIDENTIAL OPTIONS

Group Home Residential

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

The provider of group home residential service for adults who are 18 years of age or older must be licensed by DBHDS as a provider of group home residential services or a provider approved by the local department of social services as an adult foster care provider. Providers of the group home residential service for children (up to the child's 18th birthday) must be licensed by DBHDS as a children's residential provider.

Providers of group home residential services must comply with HCBS setting requirements per 42 CFR 441.301 and as described earlier in this chapter. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing group home residential services meet provider training and competency requirements as specified earlier in this chapter.

Independent Living Support

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers of independent living support services must be licensed by DBHDS as providers of supportive in-home residential services.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of

supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing independent living support services meet provider training and competency requirements as specified earlier in this chapter.

In Home Support Services

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers of in-home support services must be licensed by DBHDS as providers of supportive in-home services.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing in-home support services meet provider training and competency requirements as specified earlier in this chapter.

Shared Living

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Shared living service administrative providers must be licensed by DBHDS to provide at least one service to individuals with developmental disabilities and must manage the administrative aspects of this service, including roommate matching as needed, background checks, training, periodic onsite monitoring, and disbursing funds to the individual. The shared living administrative provider will be reimbursed a flat fee payment for the completion of these duties following submission of monthly claims for shared living service for reimbursement based upon the amount determined through the service authorization process.

Sponsored Residential

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Sponsored residential services must be provided by agencies licensed by DBHDS as a provider of sponsored residential service.

Providers must ensure that sponsors providing sponsored residential services meet provider training and competency requirements as specified earlier in this chapter.

Supervision of DSPs who are hired by the Sponsor to supplement their hours of support or to provide support during such time as the Sponsor is not present, must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Sponsored residential settings must comply with the HCBS setting requirements per 42 CFR 441.301. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

Supported Living

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

The provider must be licensed by DBHDS as a provider of supervised residential service or supportive in-home service.

Providers must ensure that staff providing supported living residential services meet provider training and competency requirements as specified earlier in this chapter.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Supported living residential service must comply with the HCBS settings requirements when provided in DBHDS licensed settings per 42 CFR 441.301 and as described earlier in this chapter. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

Self-Directed and Agency-Directed Services Companion

A provider must have a current DMAS Participation Agreement to provide agency-directed Companion services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The following types of providers can deliver agency-directed Companion services:

- Licensed by DBHDS as a provider of Residential Services, Supportive In-home Residential Services, Day Support or Respite services; or
- DMAS enrolled Personal Care/Respite Care provider agency.

Requirements for companions.

- Providers of agency-directed Companion services must ensure that companions meet staff training and competency training requirements as detailed earlier in this chapter.

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- Both agency-directed and consumer-directed companions must meet the following requirements:
 - Are at least 18 years of age;
 - Are able to read and write English to the degree required to function in this capacity and create and maintain the required documentation to support billing and possess basic math skills;
 - Are capable of following a plan for supports with minimal supervision and physically able to perform the required work;
 - Possess a valid Social Security Number that has been issued by the Social Security Administration to the person who is to function as the assistant;
 - Are capable of aiding in IADLs; and
 - Have received a tuberculosis screening according to the requirements of the Virginia Department of Health.

Consumer-directed companions must be willing to attend training at the individual's or family/caregiver's request.

Providers of agency-directed Companion services are required to have a qualified supervisor to provide ongoing supervision of all companions.

- For DBHDS licensed providers, the agency must employ or subcontract with a supervisor meeting the requirements stated in DBHDS Licensing regulations. The supervisor must provide supervision on at least a semi-annual basis to the companion.
- For providers that meet the DMAS criteria to be a personal care/respite care service provider, the agency must employ or subcontract with and directly supervise a RN or LPN with a current license or certification to practice in the Commonwealth who will provide ongoing supervision of all companions. The supervising RN or LPN must have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility or must have a bachelor's degree in a human services field and at least one year of experience working with individuals with developmental disabilities.

The supervisor must make a home visit to conduct an initial assessment prior to the start of service for all individuals enrolled in the waiver requesting and who have been approved to receive companion service. The supervisor must also perform any subsequent reassessments or changes to the plan for supports. All changes that are

indicated for an individual's plan for supports must be reviewed with and agreed to by the individual and, if appropriate, the family/caregiver.

The supervisor must make supervisory home visits as often as needed to ensure both quality and appropriateness of the service. The minimum frequency of these visits must be every 30 to 90 days under the agency-directed model, depending on the individual's needs.

Based on continuing evaluations of the companion's performance and individual's needs, the supervisor must identify any gaps in the companion's ability to function competently and must provide training as indicated.

Services facilitation requirements for consumer-directed Companion services are detailed in the Services Facilitation section of this chapter.

All individuals must have a backup plan identified 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.

Consumer Directed and Agency Directed Personal Assistance Services

A provider must have a current DMAS Participation Agreement to provide agency-directed personal assistance services. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

For agency-directed personal assistance services, the provider must be licensed by DBHDS as either a group home provider, supervised residential service provider or supportive in-home residential service provider or must meet the VDH licensing requirements or have accreditation from a CMS-recognized organization to be a personal care or respite care provider.

Personal assistance agencies must also comply with all state and federal labor laws. There is no overtime rate for agency-directed services; however, personal assistance agencies should ensure that any employees who work over 40 hours per week are compensated appropriately according to federal and state wage laws.

Supervisor requirements for agency-directed personal assistance services.

- A supervisor must provide ongoing supervision of all personal assistants.
- For personal assistance providers that are licensed by DBHDS, a supervisor meeting the requirements of DBHDS licensing regulations must provide supervision of direct support professional staff.
- For personal assistance providers that are licensed by VDH, the provider must employ or subcontract with and directly supervise an RN or an LPN who provides ongoing supervision of all assistants. The supervising RN or LPN must have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility. In addition, the RN or LPN must possess the following qualifications:

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- A license to practice in the Commonwealth of Virginia; and A satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN or LPN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect or exploitation of an incapacitated or older adult or children is acceptable;
 - The supervisor must make a home visit to conduct an initial assessment prior to the start of services for all individuals enrolled in the waiver requesting and who have been approved to receive personal assistance. The supervisor must also perform any subsequent reassessments or changes to the plan for supports. All changes that are indicated for an individual's plan for supports must be reviewed with and agreed to by the individual and, if appropriate, the family/caregiver.
 - The supervisor must make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 to 90 days under the agency-directed model, depending on the individual's needs.
 - Based on continuing evaluations of the assistant's performance and the individual's needs, the supervisor is responsible for identifying any gaps in the assistant's ability to function competently and must provide training as indicated.
 - Services facilitation requirements for consumer-directed personal assistance services are detailed in the Services Facilitation section of this chapter.
 - Requirements for personal assistants:
 - Providers of agency-directed personal assistance must ensure that personal assistants meet staff training and competency training requirements as detailed earlier in this chapter.
 - Both agency-directed and consumer-directed personal assistants must meet the following requirements:
 - Are at least 18 years of age;
 - Are able to read and write English to the degree required to function in this capacity and create and maintain the required documentation to support billing and possess basic math skills;
 - Are capable of following a plan for supports with minimal supervision and physically able to perform the required work;
 - Possess a valid Social Security Number that has been issued by the Social Security Administration to the person who is to function as the assistant;

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- Are capable of aiding in IADLs; and
 - Have received a tuberculosis screening according to the requirements of the Virginia Department of Health.

Consumer-directed personal assistants must be willing to attend training at the individual's or family/caregiver's request.

- Personal assistants employed by agencies licensed by VDH must have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual and developmental disabilities. The provider must ensure, prior to assigning assistants to support an individual, that the assistant or assistants have the required skills and training to perform the services as specified in the individual's plan for supports and related supporting documentation. Assistants' required training must be met in one of the following ways:
 - Registration with the Board of Nursing as a certified nurse aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration containing a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as a personal assistance aide. A copy of the state certificate must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the agency must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons and that the aide meets one of the other two DMAS requirements.
 - Graduation from an approved educational curriculum as listed by the Board of Nursing: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which offer certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of these Board of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, ensure that it is from a Board of Nursing-accredited institution, and maintain this documentation in the aide's personnel file for review by DMAS staff; or

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- Completion of the provider's educational curriculum: This training must be conducted by a licensed RN who meets the experiential requirements for supervisors as stated above. All graduates from the 40 hour provider training program must have a certificate of completion with the RN instructor's signature, printed name, and date of course completion.
 - Personal assistants in the agency-directed model must have a satisfactory work record, as evidenced by two references from prior job experiences, if they have worked two prior jobs, including no evidence of possible abuse, neglect, or exploitation of elderly persons, children, or adults with disabilities. If the personal assistant has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable. If possible, references should be obtained from the educational facility, vocational school, or institution where the personal assistant's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the personal assistant (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff.
 - Agency-directed personal assistance provider inability to render services and substitution of assistants. When assistants are absent or otherwise unable to render scheduled supports to individuals enrolled in the waiver, the provider must be responsible for ensuring that services continue to be provided to the affected individuals.
 - The provider may either obtain a substitute assistant from another provider, if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another personal assistance provider. The provider that holds the service authorization to provide services to the individual enrolled in the waiver must contact the support coordinator to determine if additional or modified service authorization is necessary.
 - If no other provider is available who can supply a substitute assistant, the provider must notify the individual and the individual's family/caregiver, as appropriate, and the support coordinator so that the support coordinator may find another available provider of the individual's choice.
 - During temporary, short-term lapses in coverage that are not expected to exceed approximately two weeks in duration, the following procedures must apply:

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- The service authorized provider must provide the supervision for the substitute assistant;
 - The provider of the substitute assistant must send a copy of the assistant's daily documentation signed by the assistant, the individual, and the individual's family/caregiver, as appropriate, to the provider having the service authorization; and
 - The service authorized provider must bill DMAS for services rendered by the substitute assistant.
- If a provider secures a substitute assistant, the provider agency is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS requirements. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant.

Respite Services

A provider must have a current DMAS Participation Agreement to provide agency-directed Respite. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

For agency-directed respite service, the provider must:

- Be licensed by DBHDS as a center-based respite service provider, supportive in-home respite service provider, out-of-home respite service provider or residential respite service provider;
- Be a VDSS-certified foster care home for children or a VDSS-certified adult foster care home for individuals who do not reside in that foster home;
- Meet the Virginia Department of Health (VDH) licensing requirements; or
- Have accreditation from a CMS-recognized organization to be a personal care or respite care provider.

Both agency-directed and consumer-directed respite assistants must meet the following requirements:

- Be at least 18 years of age or older;
- Be able to read and write English to the degree necessary to perform the expected tasks and create and maintain the required documentation;
- Be physically able to perform the required tasks and have the required skills to perform services as specified in the waiver individual's supporting documentation;
- Have a valid social security number that has been issued to the personal care aide by the Social Security Administration;
- Meet the requirements regarding criminal record checks and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry, as detailed earlier in this chapter.
- Understand and agree to comply with the DMAS DD Waiver requirements; and
- Receive tuberculosis (TB) screening as specified in the criteria used by the VDH.

Consumer-directed respite assistants must be willing to attend training at the individual's or family/caregiver's request. Consumer-directed respite assistants must be willing to attend training at the individual's or family/caregiver's request. Time spent attending training is decremented from the total number of authorized service hours.

Services facilitation requirements for consumer-directed respite services are detailed in the Services Facilitation section of this chapter.

Requirements for agency-directed respite assistants:

- Providers must ensure that staff providing respite must meet provider training and competency requirements as specified earlier in this chapter.
- Assistants employed by DBHDS licensed agencies must meet the requirements as specified in DBHDS Licensing regulations.
- Assistants employed by personal care agencies licensed by VDH or having accreditation from a CMS-recognized organization must have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual and developmental disabilities, as ensured by the provider prior to being assigned to support an individual. Assistants must have the required skills and training to perform the service as specified in the individual's plan for supports and related supporting documentation. An assistant's required training must be met in one of the following ways:

- Registration with the Board of Nursing as a certified nurse aide:
 - The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration containing a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as a personal assistance aide. A copy of the state certificate must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the agency must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons and that the aide meets one of the other two DMAS requirements.
- Graduation from an approved educational curriculum as listed by the Board of Nursing:
 - The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which offer certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of these Board of Nursing- approved courses, the provider must obtain a copy of the applicant's certificate, ensure that it is from a Board of Nursing-accredited institution, and maintain this documentation in the aide's personnel file for review by DMAS staff; or
 - Completion of the provider's educational curriculum: This training must be conducted by a licensed RN who meets the requirements of a supervisor as detailed below. All graduates from the 40 hour provider training program must have a certificate of completion with the RN instructor's signature, printed name, and date of course completion. as conducted by a licensed RN who must have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

- Respite assistants must have a satisfactory work record, as evidenced by two references from prior job experiences, if they have worked two prior jobs, including no evidence of possible abuse, neglect, or exploitation of elderly persons, children, or adults with disabilities. If the respite assistant has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable. If possible, references should be obtained from the educational facility, vocational school, or institution where the personal assistant's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the respite assistant (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff.

Requirements for supervisors of agency-directed respite assistants:

- A supervisor must provide ongoing supervision of all respite assistants/DSPs. For respite providers that are licensed by DBHDS, a supervisor meeting the requirements of DBHDS Licensing regulations must provide supervision of direct support professional staff.
- For respite providers who are licensed by VDH or have accreditation from a CMS-recognized organization to be a personal care or respite care provider, the provider must employ or subcontract with and directly supervise an RN or an LPN, or be an RN or LPN himself, who must provide ongoing supervision of all respite assistants. The supervising RN or LPN must have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.
- Documentation of supervision must be completed, signed, and dated by the supervisor and must include, at a minimum, the following:
 - Date of contact or observation;
 - DSP/respite assistant contacted or observed and
 - A summary of the contact or observation.
- When respite service is routine in nature, that is, occurring with a scheduled regularity for specific periods of time and offered in conjunction with personal assistance service, the supervisory visit conducted for personal assistance service may serve as the supervisory visit for the respite service. However, the supervisor, must document supervision of the respite service separately. For this purpose, the same individual record must be used with a separate section clearly marked for respite service documentation.
- Based on continuing evaluations of the assistant's performance and individual's

needs, the supervisor must identify any gaps in the assistant's ability to function competently and must provide training as indicated.

- For respite service provided based from the individual's home:
 - The supervisor must make a home visit to conduct an initial assessment prior to the start of service for all individuals enrolled in a DD Waiver who have been approved to receive respite service;
 - If the individual is also attempting to access an assessment for personal assistance services, one assessment may be conducted for both services at the same time. However, the supervisor must document supervision of the respite service separately. For this purpose, the same individual record must be used with a separate section clearly marked for respite service documentation;
 - When the service is delivered on a routine basis, the minimum frequency of required supervisory visits must be at least every 90 days;
 - When respite service is not received on a routine basis but is episodic in nature, the supervisor must conduct the initial home visit with the DSP/respite assistant immediately preceding the start of service and make a second home visit within the respite service period. The supervisor or services facilitator, as appropriate, must review the use of the respite service either every six months or upon the use of 240 respite service hours, whichever comes first.
- For center-based respite service, the supervisor must provide ongoing supervision to all DSPs/respite assistants in DBHDS-licensed settings no less than quarterly to ensure both quality and appropriateness of the service.
- For respite based in an individual's home, when assistants are absent or otherwise unable to render scheduled supports to individuals enrolled in the waiver, the provider must be responsible for ensuring that the service continues to be provided to the affected individuals.

Agency-directed Respite provider inability to render services and substitution of assistants:

When respite assistants are absent or otherwise unable to render scheduled supports to individuals enrolled in the waiver, the provider must be responsible for ensuring that services continue to be provided to the affected individuals.

- The provider may either provide another assistant, obtain a substitute assistant from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual to another respite provider.

If no other provider is available who can supply a substitute assistant, the provider must notify the individual and the individual's family/caregiver, as appropriate, and the support coordinator/case manager so that the support coordinator/case manager may find another available provider of the individual's choice.

- During temporary, short-term lapses in coverage that are not expected to exceed approximately two weeks in duration, the following procedures must apply:
 - The service authorized provider must supervise the substitute assistant;
 - The provider of the substitute assistant must send a copy of the assistant's daily documentation signed by the assistant, the individual, and the individual's family/caregiver, as appropriate, to the provider having the service authorization; and
 - The service authorized provider must bill DMAS for service rendered by the substitute assistant.

If a provider secures a substitute assistant, the provider agency must be responsible for ensuring that all DMAS requirements continue to be met, including documentation of service rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS requirements. The two providers involved must be responsible for negotiating the financial arrangements of paying the substitute assistant.

Services Facilitation

All services facilitators must be employed by or contracted with a DMAS enrolled services facilitator provider. Services facilitation providers must have sufficient resources to perform the required activities, including the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the service provided.

Providers of support coordination/case management services for an individual may also provide that individual with services facilitation.

The services facilitator must meet the following combination of work experience and relevant education that indicates the possession of the specific knowledge, skills, and abilities to perform this function. All services facilitators must possess, at a minimum, either:

- An associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth or hold a multistate licensure privilege, and demonstrate at least two years of satisfactory direct care experience supporting individuals with disabilities or older adults or children, or
- Have a bachelor's degree in a non-health or human services field and a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults. Services facilitators enrolled prior to January 11, 2016, are not required to meet the education requirements.

If the services facilitator is not an RN then, within 30 days from the start of such service, the services facilitator must contact the individual's primary health care provider to inform him/her that consumer- directed service is being provided and request skilled nursing or other consultation as needed by the individual. Prior to contacting the primary health care provider, the services facilitator must obtain the individual's written consent to make the contact. This written consent is to be retained by the services facilitator in the individual's record.

All services facilitators must possess the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include the following requirements:

Knowledge of:

- Types of functional limitations and health problems that may occur in individuals with developmental disabilities, as well as strategies to reduce limitations and health problems;
- Physical assistance that may be required by individuals with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

- Equipment and environmental modifications that may be required by individuals with developmental disabilities that reduce the need for human help and improve safety;
- Various long-term care program requirements, including nursing home and ICF/IID placement criteria; Medicaid waiver services; and other federal, state, and local resources that provide personal assistance service, respite service, and companion service;
- DD Waivers requirements, as well as the administrative duties for which the services facilitator will be responsible;
- Conducting assessments, including environmental, psychosocial, health, and functional factors, and their uses in service planning;
- Interviewing techniques;
- The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance service, companion service, and respite service, including hiring, training, managing, approving timesheets, and firing an assistant or companion;
- The principles of human behavior and interpersonal relationships; and
- General principles of record documentation.

Skills in:

- Negotiating with individuals and the individual's family/caregivers, as appropriate, and providers;
- Assessing, supporting, observing, recording, and reporting behaviors;
- Identifying, developing, or providing service to individuals with developmental disabilities; and
- Identifying services within the established system to meet the individual's needs.

Abilities to:

- Report findings of the assessment or onsite visit, either in writing or an alternative format, for individuals who have visual impairments;
- Demonstrate a positive regard for individuals and their families;
- Be persistent and remain objective;
- Work independently, performing position duties under general supervision;

- Communicate effectively, orally and in writing; and
- Develop a rapport and communicate with individuals of diverse cultural backgrounds.

All services facilitators must meet the following requirements as well:

- Have a satisfactory work record as evidenced by two references from prior job experiences from any human services work. Such references must not include any evidence of abuse, neglect, or exploitation of elderly individuals, persons with disabilities, or children;
- Submit to a criminal background check within 15 days of employment. Proof that the criminal record check was conducted must be maintained in the personnel record of the services facilitator;
- If providing service to minors, submit to a search of the VDSS Child Protective Services Central Registry; and
- Not be debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the federal List of Excluded Individuals and Entities (LEIE) database at <http://www.olg.hhs.gov/fraud/exclusions/exclusions%20list.asp>

Services facilitators who are found after the initial or any subsequent background check to

- Have been convicted of a barrier crime as defined in 12VAC30-122-20;
- Have a founded complaint confirmed by the VDSS Child Protective Services Central Registry; or
- Be listed on the LEIE database will not be compensated for services provided, and DMAS will seek refunds of overpayments.

All services facilitators must complete the DMAS-approved services facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being approved as a services facilitator or being reimbursed for waiver services. As a component of the renewal of the provider agreement, all consumer-directed services facilitators must take and pass the competency assessment every five years and achieve a score of at least 80%. The initial and all subsequent competency assessments must be kept in the services facilitator's personnel record. Failure to complete the competency assessment prior to providing this service will result in a retraction of Medicaid payment or the termination of the provider agreement, or both.

Services facilitators are required to have access to a computer with secure Internet access that meets the requirements of 45 CFR Part 164 for the electronic exchange of information. Electronic exchange of information must include, for example, checking individual eligibility, submission of service authorizations, submission of information to the fiscal employer agent, and billing for service.