COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Davis Creef**
Assistant Attorney General
Office of the Attorney General

DATE: **March 1, 2021**

SUBJECT: **Final Regulations Regarding Electronic Visit Verification, 12 VAC 30-60-65**

I am in receipt of the attached regulations to adopt regulations concerning the implementation of Electronic Visit Verification. You have asked the Office of the Attorney General to review and determine if Department of Medical Assistance Services has the statutory authority to promulgate these regulations and if they comport with applicable state law.

Virginia Code § 32.1-325 authorizes the Board of Medical Assistance Services to promulgate regulations as may be necessary to comply with federal law and carry out the provisions of the state plan. Virginia Code § 32.1-324 authorizes the Director of the Department of Medical Assistances with the Board's authority when it is not in session. It is this Office's view that the Director has the authority to promulgate the final regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act, and has not exceeded that authority.

Please note that Virginia Code § 2.2-4013(B) requires that all changes to the proposed regulation be highlighted in the final regulations. If you have any questions or need additional information about these regulations, please contact me at 786-6522.

cc: Kim F. Piner, Esq.

Attachment

Final Text

highlight

Action: Electronic Visit Verification
Stage: Final — 11/10/20 12:33 PM [latest]

12VAC30-50-130 Nursing facility services, EPSDT, including school health services, and family planning

A. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. General provisions for early and periodic screening, diagnosis, and treatment (EPSDT) of individuals younger than 21 years of age and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals younger than 21 years of age who are Medicaid eligible for medically necessary stays in acute care facilities and the accompanying attendant physician care in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local departments of social services on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. DMAS shall place appropriate utilization controls upon this service.

4. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and that are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients 21 years of age and older, provided for by § 1905(a) of the Social Security Act.

C. Community mental health services provided through early and periodic screening diagnosis and treatment (EPSDT) for individuals younger than 21 years of age. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) shall be reflected in provider records and on provider claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

1. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Adolescent" means the individual receiving the services described in this section. For the purpose of the use of this term, adolescent means an individual 12 through 20 years of age.

"Behavioral health service" means the same as defined in 12VAC30-130-5160.

"Care coordination" means the collaboration and sharing of information among health care providers involved with an individual's health care to improve the care.

"Caregiver" means the same as defined in 12VAC30-130-5160.

"Child" means an individual ages birth through 11 years.

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

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a qualified mental health professional (QMHP-A, QMHP-C, or QMHP-E) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or (iii) shall be an LMHP who has documented completion of the DBHDS PRS supervisor training who is acting within his scope of practice under state law. An LMHP providing services before April 1, 2018, shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

"DMAS" means the Department of Medical Assistance Services and its contractors.

"EPSDT" means early and periodic screening, diagnosis, and treatment.

"Family support partners" means the same as defined in 12VAC30-130-5170.

"Human services field" means the same as the term is defined by the Department of Health Professions in the document entitled Approved Degrees in Human Services and Related Fields for QMHP Registration, adopted November 3, 2017, revised February 9, 2018.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical

psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work.

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC30-130-5160.

"Person centered" means the same as defined in 12VAC30-130-5160.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590 including a "QMHP-trainee" as defined by the Department of Health Professions.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Recovery-oriented services" means the same as defined in 12VAC30-130-5160.

"Recovery, resiliency, and wellness plan" means the same as defined in 12VAC30-130-5160.

"Resiliency" means the same as defined in 12VAC30-130-5160.

"Self-advocacy" means the same as defined in 12VAC30-130-5160.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue or reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational or vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"Strength-based" means the same as defined in 12VAC30-130-5160.

"Supervision" means the same as defined in 12VAC30-130-5160.

2. Intensive in-home services (IIH) to children and adolescents younger than 21 years of age shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics and provide modeling and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote benefits of psychoeducation in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and the individual's parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

a. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

b. Service-specific provider intakes shall be required prior to the start of services at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

c. These services shall only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

3. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions (a unit is defined in 12VAC30-60-61 D 11). Day treatment programs provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group, and family counseling.

a. Service authorization shall be required for Medicaid reimbursement.

b. Service-specific provider intakes shall be required prior to the start of services, and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

c. These services shall be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

D. Therapeutic group home services and psychiatric residential treatment facility (PRTF) services for early and periodic screening diagnosis and treatment (EPSDT) of individuals younger than 21 years of age.

1. Definitions. The following words and terms when used in this subsection shall have the following meanings:

"Active treatment" means implementation of an initial plan of care (IPOC) and comprehensive individual plan of care (CIPOC).

"Assessment" means the face-to-face interaction by an LMHP, LMHP-R, LMHP-RP, or LMHP-S to obtain information from the child or adolescent and parent, guardian, or other family member, as appropriate, utilizing a tool or series of tools to provide a comprehensive evaluation and review of the child's or adolescent's mental health status. The assessment shall include a documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.

"Certificate of need" or "CON" means a written statement by an independent certification team that services in a therapeutic group home or PRTF are or were needed.

"Combined treatment services" means a structured, therapeutic milieu and planned interventions that promote (i) the development or restoration of adaptive functioning, self-care, and social skills; (ii) community integrated activities and community living skills that each individual requires to live in less restrictive environments; (iii) behavioral consultation; (iv) individual and group therapy; (v) skills restoration, the restoration of coping skills, family living and health awareness, interpersonal skills, communication skills, and stress management skills; (vi) family education and family therapy; and (vii) individualized treatment planning.

"Comprehensive individual plan of care" or "CIPOC" means a person centered plan of care that meets all of the requirements of this subsection and is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Crisis" means a deteriorating or unstable situation that produces an acute, heightened emotional, mental, physical, medical, or behavioral event.

"Crisis management" means immediately provided activities and interventions designed to rapidly manage a crisis. The activities and interventions include behavioral health care to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity. Activities shall include assessment and short-term counseling designed to stabilize the individual. Individuals are referred to long-term services once the crisis has been stabilized.

"Daily supervision" means the supervision provided in a PRTF through a resident-to-staff ratio approved by the Office of Licensure at the Department of Behavioral Health and Developmental Services with documented supervision checks every 15 minutes throughout a 24-hour period.

"Discharge planning" means family and locality-based care coordination that begins upon admission to a PRTF or therapeutic group home with the goal of transitioning the individual out of the PRTF or therapeutic group home to a less restrictive care setting with continued, clinically-appropriate, and possibly intensive, services as soon as possible upon discharge. Discharge plans shall be recommended by the treating physician, psychiatrist, or treating LMHP responsible for the overall supervision of the plan of care and shall be approved by the DMAS contractor.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Emergency admissions" means those admissions that are made when, pending a review for the certificate of need, it appears that the individual is in need of an immediate admission to a therapeutic group home or PRTF and likely does not meet the medical necessity criteria to receive crisis intervention, crisis stabilization, or acute psychiatric inpatient services.

"Emergency services" means unscheduled and sometimes scheduled crisis intervention, stabilization, acute psychiatric inpatient services, and referral assistance provided over the telephone or face-to-face if indicated, and available 24 hours a day, seven days per week.

"Family engagement" means a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, achieving desired outcomes, and promoting safety, permanency, and well-being for children, adolescents, and families. Family engagement requires ongoing opportunities for an individual to build and maintain meaningful relationships with family members, for example, frequent, unscheduled, and noncontingent telephone calls and visits between an individual and family members. Family engagement may also include enhancing or facilitating the development of the individual's relationship with other family members and supportive adults responsible for the individual's care and well-being upon discharge.

"Family engagement activity" means an intervention consisting of family psychoeducational training or coaching, transition planning with the family, family and independent living skills, and training on accessing community supports as identified in the plan of care. Family engagement activity does not include and is not the same as family therapy.

"Family therapy" means counseling services involving the individual's family and significant others to advance the treatment goals when (i) the counseling with the family member and significant others is for the direct benefit of the individual, (ii) the counseling is not aimed at addressing treatment needs of the individual's family or significant others, and (iii) the individual is present except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals. Family therapy shall be aligned with the goals of the individual's plan of care. All family therapy services furnished are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery.

"FAPT" means the family assessment and planning team.

"ICD-10" means International Statistical Classification of Diseases and Related Health Problems, 10th Revision, published by the World Health Organization.

"Independent certification team" means a team that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; has knowledge of the individual's situation; and is composed of at least one physician and one LMHP. The independent certification team shall be a DMAS-authorized contractor with contractual or employment relationships with the required team members.

"Individual" means the child or adolescent younger than 21 years of age who is receiving therapeutic group home or PRTF services.

"Individual and group therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnosis for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating plans of care using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

"Initial plan of care" or "IPOC" means a person centered plan of care established at admission that meets all of the requirements of this subsection and is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Intervention" means scheduled therapeutic treatment such as individual or group psychoeducation; skills restoration; structured behavior support and training activities; recreation, art, and music therapies; community integration activities that promote or assist in the child's or adolescent's ability to acquire coping and functional or self-regulating behavior skills; day and overnight passes; and family engagement activities. Interventions shall not include individual, group, and familytherapy; medical or dental appointments; or physician services, medication evaluation, or management provided by a licensed clinician or physician and shall not include school attendance. Interventions shall be provided in the therapeutic group home or PRTF and, when clinically necessary, in a community setting or as part of a therapeutic pass. All interventions and settings of the intervention shall be established in the plan of care.

"Plan of care" means the initial plan of care (IPOC) and the comprehensive individual plan of care (CIPOC).

"Physician" means an individual licensed to practice medicine or osteopathic medicine in Virginia, as defined in § 54.1-2900 of the Code of Virginia.

"Psychiatric residential treatment facility" or "PRTF" means the same as defined in 42 CFR 483.352 and is a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than 21 years of age in order to prevent or minimize the need for more intensive treatment.

"Recertification" means a certification for each applicant or recipient for whom therapeutic group home or PRTF services are needed.

"Room and board" means a component of the total daily cost for placement in a licensed PRTF. Residential room and board costs are maintenance costs associated with placement in a licensed PRTF and include a semi-private room, three meals and two snacks per day, and personal care items. Room and board costs are reimbursed only for PRTF settings.

"Services provided under arrangement" means services including physician and other health care services that are furnished to children while they are in a freestanding psychiatric hospital or PRTF that are billed by the arranged practitioners separately from the freestanding psychiatric hospital's or PRTF's per diem.

"Skills restoration" means a face-to-face service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the beneficiary's plan of care. Services include assisting the individual in restoring self-management, interpersonal, communication, and problem solving skills through modeling, coaching, and cueing.

"Therapeutic group home" means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents.

"Therapeutic pass" means time at home or time with family consisting of partial or entire days of time away from the therapeutic group home or psychiatric residential treatment facility as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities. Therapeutic passes are not recreational but are a therapeutic component of the plan of care and are designed for the direct benefit of the individual.

"Treatment planning" means development of a person centered plan of care that is specific to the individual's unique treatment needs and acuity levels.

2. Therapeutic group home services pursuant to 42 CFR 440.130(d).

a. Therapeutic group home services for children and adolescents younger than 21 years of age shall provide therapeutic services to restore or maintain appropriate skills necessary to promote prosocial behavior and healthy living, including skills restoration, family living and health awareness, interpersonal skills, communication skills, and stress management skills. Therapeutic services shall also engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members. Each component of therapeutic group home services is provided for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. These services are provided under 42 CFR 440.130(d) in accordance with the rehabilitative services benefit.

b. The plan of care shall include individualized activities, including a minimum of one intervention per 24-hour period in addition to individual, group, and family therapies. Daily interventions are not required when there is documentation to justify clinical or medical reasons for the individual's deviations from the plan of care. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the plan of care shall be documented along with a clinical or medical justification for the deviation.

c. Medical necessity criteria for admission to a therapeutic group home. The following requirements for severity of need and intensity and quality of service shall be met to satisfy the medical necessity criteria for admission.

(1) Severity of need required for admission. All of the following criteria shall be met to satisfy the criteria for severity of need:

(a) The individual's behavioral health condition can only be safely and effectively treated in a 24-hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school, and community functioning caused by current mental health symptoms consistent with a DSM-5 diagnosis.

(b) The certificate of need must demonstrate all of the following: (i) ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual; (ii) proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and (iii) the services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

(c) The state uniform assessment tool shall be completed. The assessment shall demonstrate at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. A moderate impairment is evidenced by, but not limited to (i) frequent conflict in the family setting such as credible threats of physical harm, where "frequent" means more than expected for the individual's age and developmental level; (ii) frequent inability to accept age-appropriate direction and supervision from caretakers, from family members, at school, or in the home or community; (iii) severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions; (iv) impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community; (v) limited ability to consider the effect of one's inappropriate conduct on others; and (vi) interactions consistently involving conflict, which may include impulsive or abusive behaviors.

(d) Less restrictive community-based services have been given a fully adequate trial and were unsuccessful or, if not attempted, have been considered, but in either situation were determined to be unable to meet the individual's treatment needs and the reasons for that are discussed in the certificate of need.

(e) The individual's symptoms, or the need for treatment in a 24 hours a day, seven days a week level of care (LOC), are not primarily due to any of the following: (i) intellectual disability, developmental disability, or autistic spectrum disorder; (ii) organic mental disorders, traumatic brain injury, or other medical condition; or (iii) the individual does not require a more intensive level of care.

(f) The individual does not require primary medical or surgical treatment.

(2) Intensity and quality of service necessary for admission. All of the following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The therapeutic group home service has been prescribed by a psychiatrist, psychologist, or other LMHP who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the individual.

(b) The therapeutic group home is not being used for clinically inappropriate reasons, including (i) an alternative to incarceration or preventative detention; (ii) an alternative to a parent's, guardian's, or agency's capacity to provide a place of residence for the individual; or (iii) a treatment intervention when other less restrictive alternatives are available.

(c) The individual's treatment goals are included in the service specific provider intake and include behaviorally defined objectives that require and can reasonably be achieved within a therapeutic group home setting.

(d) The therapeutic group home is required to coordinate with the individual's community resources, including schools and FAPT as appropriate, with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

(e) The therapeutic group home program must incorporate nationally established, evidence-based, trauma-informed services and supports that promote recovery and resiliency.

(f) Discharge planning begins upon admission, with concrete plans for the individual to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the plan of care.

(3) Continued stay criteria. The following criteria shall be met in order to satisfy the criteria for continued stay:

(a) All of the admission guidelines continue to be met and continue to be supported by the written clinical documentation.

(b) The individual shall meet one of the following criteria: (i) the desired outcome or level of functioning has not been restored or improved in the timeframe outlined in the individual's plan of care or the individual continues to be at risk for relapse based on history or (ii) the nature of the functional gains is tenuous and use of less intensive services will not achieve stabilization.

(c) The individual shall meet one of the following criteria: (i) the individual has achieved initial CIPOC goals, but additional goals are indicated that cannot be met at a lower level of care; (ii) the individual is making satisfactory progress toward meeting goals but has not attained plan of care goals, and the goals cannot be addressed at a lower level of care; (iii) the individual is not making progress, and the plan of care has been modified to identify more effective interventions; or (iv)

there are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.

(d) There is a written, up-to-date discharge plan that (i) identifies the custodial parent or custodial caregiver at discharge; (ii) identifies the school the individual will attend at discharge, if applicable; (iii) includes individualized education program (IEP) and FAPT recommendations, if necessary; (iv) outlines the aftercare treatment plan (discharge to another residential level of care is not an acceptable discharge goal); and (v) lists barriers to community reintegration and progress made on resolving these barriers since last review.

(e) The active plan of care includes structure for combined treatment services and activities to ensure the attainment of therapeutic mental health goals as identified in the plan of care. Combined treatment services reinforce and practice skills learned in individual, group, and family therapy such as community integration skills, coping skills, family living and health awareness skills, interpersonal skills, and stress management skills. Combined treatment services may occur in group settings, in one-on-one interactions, or in the home setting during a therapeutic pass. In addition to the combined treatment services, the child or adolescent must also receive psychotherapy services, care coordination, family-based discharge planning, and locality-based transition activities. The child or adolescent shall receive intensive family interventions at least twice per month, although it is recommended that the intensive family interventions be provided at a frequency of one family therapy session per week. Family involvement begins immediately upon admission to therapeutic group home. If the minimum requirement cannot be met, the reasons must be reported, and continued efforts to involve family members must also be documented. Other family members or supportive adults may be included as indicated in the plan of care.

(f) Less restrictive treatment options have been considered but cannot yet meet the individual's treatment needs. There is sufficient current clinical documentation or evidence to show that therapeutic group home level of care continues to be the least restrictive level of care that can meet the individual's mental health treatment needs.

(4) Discharge shall occur if any of the following applies: (i) the level of functioning has improved with respect to the goals outlined in the plan of care, and the individual can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the individual no longer benefits from service as evidenced by absence of progress toward plan of care goals for a period of 60 days; or (iii) other less intensive services may achieve stabilization.

d. The following clinical activities shall be required for each therapeutic group home resident:

(1) An assessment be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S.

(2) A face-to-face evaluation shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 calendar days prior to admission with a documented DSM-5 or ICD-10 diagnosis.

(3) A certificate of need shall be completed by an independent certification team according to the requirements of subdivision D 4 of this section. Recertification shall occur at least every 60 calendar days by an LMHP, LMHP-R, LMHP-RP, or LMHP-S acting within his scope of practice.

(4) An IPOC that is specific to the individual's unique treatment needs and acuity levels. The IPOC shall be completed on the day of admission by an LMHP, LMHP-

R, LMHP-RP, or LMHP-S and shall be signed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual and a family member or legally authorized representative. The IPOC shall include all of the following:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Orders for medications, psychiatric, medical, dental, and any special health care needs whether or not provided in the facilities, treatments, restorative and rehabilitative services, activities, therapies, therapeutic passes, social services, community integration, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care; and

(g) Plans for discharge.

(5) A CIPOC shall be completed no later than 14 calendar days after admission. The CIPOC shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and shall reflect the need for therapeutic group home care;

(b) Be based on input from school, home, other health care providers, FAPT if necessary, the individual, and the family or legal guardian;

(c) Shall state treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

(d) Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

(e) Include a comprehensive discharge plan with necessary, clinically appropriate community services to ensure continuity of care upon discharge with the individual's family, school, and community.

(6) The CIPOC shall be reviewed, signed, and dated every 30 calendar days by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or primary caregiver. Updates shall be signed and dated by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or legally authorized representative. The review shall include all of the following:

(a) The individual's response to the services provided;

(b) Recommended changes in the plan as indicated by the individual's overall response to the CIPOC interventions; and

(c) Determinations regarding whether the services being provided continue to be required.

(7) Crisis management, clinical assessment, and individualized therapy shall be provided to address both behavioral health and substance use disorder needs as indicated in the plan of care to address intermittent crises and challenges within the therapeutic group home setting or community settings as defined in the plan of care and to avoid a higher level of care.

(8) Care coordination shall be provided with medical, educational, and other behavioral health providers and other entities involved in the care and discharge planning for the individual as included in the plan of care.

(9) Weekly individual therapy shall be provided in the therapeutic group home, or other settings as appropriate for the individual's needs, by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61.

(10) Weekly (or more frequently if clinically indicated) group therapy shall be provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the plan of care.

(11) Family treatment shall be provided as clinically indicated, provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, and documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the plan of care.

(12) Family engagement activities shall be provided in addition to family therapy or counseling. Family engagement activities shall be provided at least weekly as outlined in the plan of care, and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the plan of care. For each service authorization period when family engagement is not possible, the therapeutic group home shall identify and document the specific barriers to the individual's engagement with the individual's family or legally authorized representatives. The therapeutic group home shall document on a weekly basis the reasons why family engagement is not occurring as required. The therapeutic group home shall document alternative family engagement strategies to be used as part of the interventions in the plan of care and request approval of the revised plan of care by DMAS. When family engagement is not possible, the therapeutic group home shall collaborate with DMAS on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the plan of care.

(13) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities.

(a) The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass.

(b) If a facility staff member does not accompany the individual on the therapeutic pass and the therapeutic pass exceeds 24 hours, the provider shall make daily contacts with the family and be available 24 hours per day to address concerns, incidents, or crises that may arise during the pass.

(c) Contact with the family shall occur within seven calendar days of the therapeutic pass to discuss the accomplishments and challenges of the therapeutic pass along with an update on progress toward plan of care goals and any necessary changes to the plan of care.

(d) Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating LMHP and documented in the plan of care. Additional therapeutic passes shall require service authorization. Any unauthorized therapeutic passes shall result in retraction for those days of service.

(14) Discharge planning shall begin at admission and continue throughout the individual's stay at the therapeutic group home. The family or guardian, the community services board (CSB), the family assessment and planning team (FAPT) case manager, and the DMAS contracted care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and available services in the community. Prior to discharge, the therapeutic group home shall submit an active and viable discharge plan to the DMAS contractor for review. Once the DMAS contractor approves the discharge plan, the provider shall begin actively collaborating with the family or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The therapeutic group home shall request permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The therapeutic group home shall request information from post-discharge providers to establish that the planning of pending services and transition planning activities has begun, shall establish that the individual has been enrolled in school, and shall provide individualized education program recommendations to the school if necessary. The therapeutic group home shall inform the DMAS contractor of all scheduled appointments within 30 calendar days of discharge and shall notify the DMAS contractor within one business day of the individual's discharge date from the therapeutic group home.

(15) Room and board costs shall not be reimbursed. Facilities that only provide independent living services or nonclinical services that do not meet the requirements of this subsection are not eligible for reimbursement.

(16) Therapeutic group home services providers shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(17) Individuals shall be discharged from this service when treatment goals are met or other less intensive services may achieve stabilization.

(18) Services that are based upon incomplete, missing, or outdated service-specific provider intakes or plans of care shall be denied reimbursement.

(19) Therapeutic group home services may only be rendered by and within the scope of practice of an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH as defined in 12VAC35-105-20.

(20) The psychiatric residential treatment facility or therapeutic group home shall coordinate necessary services and discharge planning with other providers as medically and clinically necessary. Documentation of this care coordination shall be maintained by the facility or group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, what information was transmitted, and recommended next steps.

(21) Failure to perform any of the items described in this subsection shall result in a retraction of the per diem for each day of noncompliance.

3. PRTF services are a 24-hour, supervised, clinically and medically necessary out-of-home program designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of an individual younger than 21 years of age in order to prevent or minimize the need for more inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. In order to be covered for individuals younger than 21 years of age, these services shall (i) meet DMAS-approved psychiatric medical necessity criteria or be approved as an EPSDT service based upon a diagnosis made by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is

practicing within the scope of his license and (ii) be reflected in provider records and on the provider's claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. PRTF services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by a psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state.

b. Providers of PRTF services shall be licensed by DBHDS.

c. PRTF services are reimbursable only when the treatment program is fully in compliance with (i) 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151 (a) and (b) and 42 CFR 441.152 through 42 CFR 441.156 and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be service authorized, and the treatment must meet DMAS requirements for clinical necessity.

d. The PRTF benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160 that are provided under the direction of a physician pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals and shall involve active treatment designed to achieve the child's discharge from PRTF services at the earliest possible time. The PRTF services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the PRTF, as long as the PRTF (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the PRTF. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

e. PRTFs, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) nonemergency transportation services; and (x) emergency services.

f. PRTF services shall include assessment and reassessment; room and board; daily supervision; combined treatment services; individual, family, and group therapy; care coordination; interventions; general or special education; medical treatment (including medication, coordination of necessary medical services, and 24-hour onsite nursing); specialty services; and discharge planning that meets the medical and clinical needs of the individual.

g. Medical necessity criteria for admission to a PRTF. The following requirements for severity of need and intensity and quality of service shall be met to satisfy the medical necessity criteria for admission:

(1) Severity of need required for admission. The following criteria shall be met to satisfy the criteria for severity of need:

(a) There is clinical evidence that the individual has a DSM-5 disorder that is amenable to active psychiatric treatment.

(b) There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

(c) Either (i) there is clinical evidence that the individual would be a risk to self or others if the individual were not in a PRTF or (ii) as a result of the individual's mental disorder, there is an inability for the individual to adequately care for his own physical needs, and caretakers, guardians, or family members are unable to safely fulfill these needs, representing potential serious harm to self.

(d) The individual requires supervision seven days per week, 24 hours per day to develop skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to develop the adaptive and functional behavior that will allow the individual to live outside of a PRTF setting.

(e) The individual's current living environment does not provide the support and access to therapeutic services needed.

(f) The individual is medically stable and does not require the 24-hour medical or nursing monitoring or procedures provided in a hospital level of care.

(2) Intensity and quality of service necessary for admission. The following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

(b) The program provides supervision seven days per week, 24 hours per day to assist with the development of skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of a PRTF setting.

(c) An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour nursing services availability. This plan includes (i) at least once-a-week psychiatric reassessments; (ii) intensive family or support system involvement occurring at least once per week or valid reasons identified as to why such a plan is not clinically appropriate or feasible; (iii) psychotropic medications, when used, are to be used with specific target symptoms identified; (iv) evaluation for current medical problems; (v) evaluation for concomitant substance use issues; and (vi) linkage or coordination with the individual's community resources, including the local school division and FAPT case manager, as appropriate, with the goal of returning the individual to his regular social environment as soon as possible, unless contraindicated. School contact should address an individualized educational plan as appropriate.

(d) A urine drug screen is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

(3) Criteria for continued stay. The following criteria shall be met to satisfy the criteria for continued stay:

(a) Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following: (i) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and

intensity of service needs); (ii) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs); or (iii) that disposition planning or attempts at therapeutic reentry into the community have resulted in or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued PRTF treatment. Subjective opinions without objective clinical information or evidence are not sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

(b) There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the individual can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

(c) There is evidence that the plan of care is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the individual's ability to return to a less-intensive level of care.

(d) The current or revised plan of care can be reasonably expected to bring about significant improvement in the problems meeting the criteria in subdivision 3 c (3) (a) of this subsection, and this is documented in weekly progress notes written and signed by the provider.

(e) There is evidence of intensive family or support system involvement occurring at least once per week, unless there is an identified valid reason why it is not clinically appropriate or feasible.

(f) A discharge plan is formulated that is directly linked to the behaviors or symptoms that resulted in admission and begins to identify appropriate post-PRTF resources including the local school division and FAPT case manager as appropriate.

(g) All applicable elements in admission-intensity and quality of service criteria are applied as related to assessment and treatment if clinically relevant and appropriate.

(4) Discharge criteria. Discharge shall occur if any of the following applies: (i) the level of functioning has improved with respect to the goals outlined in the plan of care, and the individual can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the individual no longer benefits from service as evidenced by absence of progress toward plan of care goals for a period of 30 days; or (iii) other less intensive services may achieve stabilization.

h. The following clinical activities shall be required for each PRTF resident:

(1) A face-to-face assessment shall be performed by an LMHP, LMHP-R, LMHP-RS, or LMHP-S within 30 calendar days prior to admission and weekly thereafter and shall document a DSM-5 or ICD-10 diagnosis.

(2) A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 4. Recertification shall occur at least every 30 calendar days by a physician acting within his scope of practice.

(3) The initial plan of care (IPOC) shall be completed within 24 hours of admission by the treatment team. The IPOC shall include:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Any orders for medications, psychiatric, medical, dental, and any special health care needs, whether or not provided in the facility; education or special education; treatments; interventions; and restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care;

(g) Plans for discharge; and

(h) Signature and date by the individual, parent, or legally authorized representative, a physician, and treatment team members.

(4) The CIPOC shall be completed and signed no later than 14 calendar days after admission by the treatment team. The PRTF shall request authorizations from families to release confidential information to collect information from medical and behavioral health treatment providers, schools, FAPT, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the CIPOC. The CIPOC shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for PRTF care;

(b) Be developed by an interdisciplinary team of physicians and other personnel specified in subdivision 3 d 4 of this subsection who are employed by or provide services to the individual in the facility in consultation with the individual, family member, or legally authorized representative, or appropriate others into whose care the individual will be released after discharge;

(c) Shall state treatment objectives that shall include measurable, evidence-based, and short-term and long-term goals and objectives; family engagement activities; and the design of community-based aftercare with target dates for achievement;

(d) Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the individual and family treatment needs; and

(e) Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.

(5) The CIPOC shall be reviewed every 30 calendar days by the team specified in subdivision 3 d 4 of this subsection to determine that services being provided are or were required from a PRTF and to recommend changes in the plan as indicated by the individual's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the individual, parent, or legally authorized representative, a physician, and treatment team members.

(6) Individual therapy shall be provided three times per week (or more frequently based upon the individual's needs) provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the requirements in this subsection and 12VAC30-60-61.

(7) Group therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the requirements in this subsection.

(8) Family therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the individual and family or legally authorized representative's goals and the requirements in this subsection.

(9) Family engagement shall be provided in addition to family therapy or counseling. Family engagement shall be provided at least weekly as outlined in the plan of care and daily communication with the treatment team representative and the treatment team representative and the family or legally authorized representative shall be part of the family engagement strategies in the plan of care. For each service authorization period when family engagement is not possible, the PRTF shall identify and document the specific barriers to the individual's engagement with his family or legally authorized representatives. The PRTF shall document on a weekly basis the reasons that family engagement is not occurring as required. The PRTF shall document alternate family engagement strategies to be used as part of the interventions in the plan of care and request approval of the revised plan of care by DMAS. When family engagement is not possible, the PRTF shall collaborate with DMAS on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the plan of care.

(10) Three interventions shall be provided per 24-hour period including nights and weekends. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the plan of care. Any deviation from the plan of care shall be documented along with a clinical or medical justification for the deviation based on the needs of the individual.

(11) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with community-based and facility-based interventions to promote discharge planning, community integration, and family engagement. Therapeutic passes include activities as listed in subdivision 2 d (13) of this ~~section~~ subsection. Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating physician and documented in the plan of care. Additional therapeutic passes shall require service authorization from DMAS. Any unauthorized therapeutic passes not approved by the provider or DMAS shall result in retraction for those days of service.

(12) Discharge planning shall begin at admission and continue throughout the individual's placement at the PRTF. The parent or legally authorized representative, the community services board (CSB), the family assessment planning team (FAPT) case manager, if appropriate, and the DMAS contracted care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and identify the available services in the community. Prior to discharge, the PRTF shall submit an active discharge plan to the DMAS contractor for review. Once the DMAS contractor approves the discharge plan, the provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The PRTF shall request written permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The PRTF shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the individual has been enrolled in school, and shall provide individualized education program recommendations to the school if necessary. The PRTF shall inform the DMAS contractor of all scheduled appointments within 30 calendar days of discharge and

shall notify the DMAS contractor within one business day of the individual's discharge date from the PRTF.

(13) Failure to perform any of the items as described in subdivisions 3 h (1) through 3 h (12) of this subsection up until the discharge of the individual shall result in a retraction of the per diem and all other contracted and coordinated service payments for each day of noncompliance.

i. The team developing the CIPOC shall meet the following requirements:

(1) At least one member of the team must have expertise in pediatric behavioral health. Based on education and experience, preferably including competence in child or adolescent psychiatry, the team must be capable of all of the following: assessing the individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the individual's family or legally authorized representative; setting treatment objectives; and prescribing therapeutic modalities to achieve the CIPOC's objectives.

(2) The team shall include one of the following:

(a) A board-eligible or board-certified psychiatrist;

(b) A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or

(c) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed clinical psychologist.

(3) The team shall also include one of the following: an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

4. Requirements for independent certification teams applicable to both therapeutic group homes and PRTFs:

a. The independent certification team shall certify the need for PRTF or therapeutic group home services and issue a certificate of need document within the process and timeliness standards as approved by DMAS under contractual agreement with the DMAS contractor.

b. The independent certification team shall be approved by DMAS through a memorandum of understanding with a locality or be approved under contractual agreement with the DMAS contractor. The team shall initiate and coordinate referral to the family assessment and planning team (FAPT) as defined in §§ 2.2-5207 and 2.2-5208 of the Code of Virginia to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.

c. The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

d. The LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, as part of the independent certification team, shall meet with an individual and the individual's parent or legally authorized representative within two business days from a request to assess the individual's needs and begin the process to certify the need for an out-of-home placement.

e. The independent certification team shall meet with an individual and the individual's parent or legally authorized representative within 10 business days from a request to certify the need for an out-of-home placement.

f. The independent certification team shall assess the treatment needs of the individual to issue a certificate of need (CON) for the most appropriate medically necessary services. The certification shall include the dated signature and credentials for each of the team members who rendered the certification. Referring or treatment providers shall not actively participate during the certification process but may provide supporting clinical documentation to the certification team.

g. The CON shall be effective for 30 calendar days prior to admission.

h. The independent certification team shall provide the completed CON to the facility within one calendar day of completing the CON.

i. The individual and the individual's parent or legally authorized representative shall have the right to freedom of choice of service providers.

j. If the individual or the individual's parent or legally authorized representative disagrees with the independent certification team's recommendation, the parent or legally authorized representative may appeal the recommendation in accordance with 12VAC30-110.

k. If the LMHP, as part of the independent certification team, determines that the individual is in immediate need of treatment, the LMHP shall refer the individual to an appropriate Medicaid-enrolled crisis intervention provider, crisis stabilization provider, or inpatient psychiatric provider in accordance with 12VAC30-50-226 or shall refer the individual for emergency admission to a PRTF or therapeutic group home under subdivision 4 m of this subsection and shall also alert the individual's managed care organization.

l. For individuals who are already eligible for Medicaid at the time of admission, the independent certification team shall be a DMAS-authorized contractor with competence in the diagnosis and treatment of mental illness, preferably in child psychiatry, and have knowledge of the individual's situation and service availability in the individual's local service area. The team shall be composed of at least one physician and one LMHP, including LMHP-S, LMHP-R, and LMHP-RP. An individual's parent or legally authorized representative shall be included in the certification process.

m. For emergency admissions, an assessment must be made by the team responsible for the comprehensive individual plan of care (CIPOC). Reimbursement shall only occur when a certificate of need is issued by the team responsible for the CIPOC within 14 calendar days after admission. The certification shall cover any period of time after admission and before claims are made for reimbursement by Medicaid. After processing an emergency admission, the therapeutic group home, PRTF, or institution for mental diseases (IMD) shall notify the DMAS contractor within five calendar days of the individual's status as being under the care of the facility.

n. For all individuals who apply and become eligible for Medicaid while an inpatient in a facility or program, the certification team shall refer the case to the DMAS contractor for referral to the local FAPT to facilitate care coordination and consideration of educational coverage and other supports not covered by DMAS.

o. For individuals who apply and become eligible for Medicaid while an inpatient in the facility or program, the certification shall be made by the team responsible for the CIPOC and shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. Upon the individual's enrollment into the Medicaid program, the therapeutic group home,

PRTF, or IMD shall notify the DMAS contractor of the individual's status as being under the care of the facility within five calendar days of the individual becoming eligible for Medicaid benefits.

5. Service authorization requirements applicable to both therapeutic group homes and PRTFs:

a. Authorization shall be required and shall be conducted by DMAS using medical necessity criteria specified in this subsection.

b. An individual shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this subsection to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the individual will require a mental health evaluation prior to admission by an LMHP affiliated with the independent certification team to establish a diagnosis and recommend and coordinate referral to the available treatment options.

c. At authorization, an initial length of stay shall be agreed upon by the individual and parent or legally authorized representative with the treating provider, and the treating provider shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement, and obtaining authorization for continued stay.

d. Information that is required to obtain authorization for these services shall include:

(1) A completed state-designated uniform assessment instrument approved by DMAS;

(2) A certificate of need completed by an independent certification team specifying all of the following:

(a) The ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the individual;

(b) Alternative community-based care was not successful;

(c) Proper treatment of the individual's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and

(d) The services can reasonably be expected to improve the individual's condition or prevent further regression so that a more intensive level of care will not be needed;

(3) Diagnosis as defined in the DSM-5 and based on (i) an evaluation by a psychiatrist or LMHP that has been completed within 30 calendar days of admission or (ii) a diagnosis confirmed in writing by an LMHP after review of a previous evaluation completed within one year of admission;

(4) A description of the individual's behavior during the seven calendar days immediately prior to admission;

(5) A description of alternate placements and community mental health and rehabilitation services and traditional behavioral health services pursued and attempted and the outcomes of each service;

(6) The individual's level of functioning and clinical stability;

(7) The level of family involvement and supports available; and

(8) The initial plan of care (IPOC).

6. Continued stay criteria requirements applicable to both therapeutic group homes and PRTFs. For a continued stay authorization or a reauthorization to occur, the individual shall meet the medical necessity criteria as defined in this subsection to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by DMAS. A current plan of care and a current (within 30 calendar days) summary of progress related to the goals and objectives of the plan of care shall be submitted to DMAS for continuation of the service. The service provider shall also submit:

a. A state uniform assessment instrument, completed no more than 30 business days prior to the date of submission;

b. Documentation that the required services have been provided as defined in the plan of care;

c. Current (within the last 14 calendar days) information on progress related to the achievement of all treatment and discharge-related goals; and

d. A description of the individual's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge planning and care coordination, and need for a residential level of care.

7. EPSDT services requirements applicable to therapeutic group homes and PRTFs. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT. EPSDT services may involve service modalities not available to other individuals, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by a DMAS contractor. In unique EPSDT cases, DMAS may authorize specialized services beyond the standard therapeutic group home or PRTF medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each individual. Treating service providers authorized to deliver medically necessary EPSDT services in therapeutic group homes and PRTFs on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence-based progress measurement criteria described in the plan of care and approved for reimbursement by DMAS. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT PRTF or therapeutic group home service.

8. Inpatient psychiatric services shall be covered for individuals younger than 21 years of age for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2) for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services meet the requirements set forth in subdivision 7 of this subsection.

a. Inpatient psychiatric services shall be provided under the direction of a physician.

b. Inpatient psychiatric services shall be provided by (i) a psychiatric hospital that undergoes a state survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in 42 CFR 482.60 or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by the Centers for Medicare and Medicaid Services (CMS); or (ii) a hospital with an inpatient psychiatric program that undergoes a state survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in 42 CFR part 482 or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

c. Inpatient psychiatric admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25.

d. PRTF services are reimbursable only when the treatment program is fully in compliance with (i) 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151(a) and 42 CFR 441.151 (b) and 42 CFR 441.152 through 42 CFR 441.156 and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be service authorized and the treatment must meet DMAS requirements for clinical necessity.

e. The inpatient psychiatric benefit for individuals younger than 21 years of age shall include services that are provided pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals and shall involve active treatment designed to achieve the individual's discharge from inpatient status at the earliest possible time. The inpatient psychiatric benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the inpatient psychiatric facility who is licensed to prescribe drugs shall be considered the referral.

f. State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order pharmacy services and emergency services. Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order the following services: (i) medical and psychological services including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) nonemergency transportation services; and (viii) emergency services. (Emergency services means the same as is set forth in 12VAC30-50-310 B.)

E. Mental health family support partners.

1. Mental health family support partners are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support the caregiver and an individual's self-help efforts to improve health recovery resiliency and wellness. Mental health family support partners is a peer support service and is a strength-based, individualized service provided to the caregiver of a Medicaid-eligible individual younger than 21 years of age with a mental health disorder that is the focus of support. The services provided to the caregiver and individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for individuals younger than 21 years of age with complex needs who are involved with multiple systems and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar mental health disorder or (ii) an adult with personal experience with a family member with a similar mental health disorder with experience navigating behavioral health care services. The PRS shall perform the service within the scope of his knowledge, lived experience, and education.

2. Under the clinical oversight of the LMHP making the recommendation for mental health family support partners, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the LMHP's recommendation for service, the individual's and the caregiver's perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual and the individual's caregiver. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by the LMHP, the PRS, the direct supervisor, the individual, and the individual's caregiver within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual and the caregiver to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

3. Documentation of required activities shall be required as set forth in 12VAC30-130-5200 A, C, and E through J.

4. Limitations and exclusions to service delivery shall be the same as set forth in 12VAC30-130-5210.

5. Caregivers of individuals younger than 21 years of age who qualify to receive mental health family support partners shall (i) care for an individual with a mental health disorder who requires recovery assistance and (ii) meet two or more of the following:

a. Individual and his caregiver need peer-based recovery-oriented services for the maintenance of wellness and the acquisition of skills needed to support the individual.

b. Individual and his caregiver need assistance to develop self-advocacy skills to assist the individual in achieving self-management of the individual's health status.

c. Individual and his caregiver need assistance and support to prepare the individual for a successful work or school experience.

d. Individual and his caregiver need assistance to help the individual and caregiver assume responsibility for recovery.

6. Individuals 18, 19, and 20 years of age who meet the medical necessity criteria in 12VAC30-50-226 B 7 e, who would benefit from receiving peer supports directly and who choose to receive mental health peer support services directly instead of through their caregiver, shall be permitted to receive mental health peer support services by an appropriate PRS.

7. To qualify for continued mental health family support partners, medical necessity criteria shall continue to be met, and progress notes shall document the status of progress relative to the goals identified in the recovery, resiliency, and wellness plan.

8. Discharge criteria from mental health family support partners shall be the same as set forth in 12VAC30-130-5180 E.

9. Mental health family support partners services shall be rendered on an individual basis or in a group.

10. Prior to service initiation, a documented recommendation for mental health family support partners services shall be made by a licensed mental health

professional (LMHP) who is acting within his scope of practice under state law. The recommendation shall verify that the individual meets the medical necessity criteria set forth in subdivision 5 of this subsection. The recommendation shall be valid for no longer than 30 calendar days.

11. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification required by DBHDS in order to be eligible to register with the Virginia Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required. The PRS shall perform mental health family support partners services under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan.

12. The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

a. Acute care general and emergency department hospital services licensed by the Department of Health.

b. Freestanding psychiatric hospital and inpatient psychiatric unit licensed by the Department of Behavioral Health and Developmental Services.

c. Psychiatric residential treatment facility licensed by the Department of Behavioral Health and Developmental Services.

d. Therapeutic group home licensed by the Department of Behavioral Health and Developmental Services.

e. Outpatient mental health clinic services licensed by the Department of Behavioral Health and Developmental Services.

f. Outpatient psychiatric services provider.

g. A community mental health and rehabilitative services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following community mental health and rehabilitative services as defined in this section, 12VAC30-50-226, 12VAC30-50-420, or 12VAC30-50-430 for which the individual younger than 21 years meets medical necessity criteria: (i) intensive in home; (ii) therapeutic day treatment; (iii) day treatment or partial hospitalization; (iv) crisis intervention; (v) crisis stabilization; (vi) mental health skill building; or (vii) mental health case management.

13. Only the licensed and enrolled provider as referenced in subdivision 12 of this subsection shall be eligible to bill and receive reimbursement from DMAS for mental health family support partner services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS. Reimbursement shall be subject to retraction for any billed service that is determined not to be in compliance with DMAS requirements.

14. Supervision of the PRS shall meet the requirements set forth in 12VAC30-50-226 B 7 l.

F. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

G. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12VAC30-130-5000 et seq.

H. Services facilitators shall be required for all consumer-directed personal care services consistent with the requirements set out in 12VAC30-120-935.

I. Behavioral therapy services shall be covered for individuals younger than 21 years of age.

1. Definitions. The following words and terms when used in this subsection shall have the following meanings unless the context clearly indicates otherwise:

"Behavioral therapy" means systematic interventions provided by licensed practitioners acting within the scope of practice defined under a Virginia Department of Health Professions regulatory board and covered as remedial care under 42 CFR 440.130(d) to individuals younger than 21 years of age. Behavioral therapy includes applied behavioral analysis. Family training related to the implementation of the behavioral therapy shall be included as part of the behavioral therapy service. Behavioral therapy services shall be subject to clinical reviews and determined as medically necessary. Behavioral therapy may be provided in the individual's home and community settings as deemed by DMAS as medically necessary treatment.

"Counseling" means a professional mental health service that can only be provided by a person holding a license issued by a health regulatory board at the Department of Health Professions, which includes conducting assessments, making diagnoses of mental disorders and conditions, establishing treatment plans, and determining treatment interventions.

"Individual" means the child or adolescent younger than 21 years of age who is receiving behavioral therapy services.

"Primary care provider" means a licensed medical practitioner who provides preventive and primary health care and is responsible for providing routine EPSDT screening and referral and coordination of other medical services needed by the individual.

2. Behavioral therapy services shall be designed to enhance communication skills and decrease maladaptive patterns of behavior, which if left untreated, could lead to more complex problems and the need for a greater or a more intensive level of care. The service goal shall be to ensure the individual's family or caregiver is trained to effectively manage the individual's behavior in the home using modification strategies. All services shall be provided in accordance with the ISP and clinical assessment summary.

3. Behavioral therapy services shall be covered when recommended by the individual's primary care provider or other licensed physician, licensed physician assistant, or licensed nurse practitioner and determined by DMAS to be medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from either developmental, behavioral, or mental disabilities. Criteria for medical necessity are set out in 12VAC30-60-61 F. Service-specific provider intakes shall be required at the onset of these services in order to receive authorization for reimbursement. Individual service plans (ISPs) shall be required throughout the entire duration of services. The services shall be provided in accordance with the individual service plan and clinical assessment summary. These services shall be provided in settings that are natural or normal for a child or adolescent without a disability, such as the individual's home, unless there is justification in the ISP, which has been authorized for reimbursement, to include service settings that promote a generalization of behaviors across different settings to maintain the targeted functioning outside of the treatment setting in the individual's home and the larger community within which the individual resides. Covered behavioral therapy services shall include:

a. Initial and periodic service-specific provider intake as defined in 12VAC30-60-61 F;

b. Development of initial and updated ISPs as established in 12VAC30-60-61 F;

c. Clinical supervision activities. Requirements for clinical supervision are set out in 12VAC30-60-61 F;

d. Behavioral training to increase the individual's adaptive functioning and communication skills;

e. Training a family member in behavioral modification methods as established in 12VAC30-60-61 F;

f. Documentation and analysis of quantifiable behavioral data related to the treatment objectives; and

g. Care coordination.

4. All personal care services rendered to children under the authority of 42 CFR 440.40(b) shall comply with the requirements of 12VAC30-60-65 with regard to electronic visit verification.

J. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions, and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as

services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy and occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services.

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation, and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include dressing changes, maintaining patent airways, medication administration or monitoring, and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant, or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual or developmental disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialists, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This professional develops a written plan for meeting the needs of the individual, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Individuals requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of an individual's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D (12VAC30-50-530). Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for an individual who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the individual is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the individual's IEP. Individuals requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in an individual's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the individual shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if an individual is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

K. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

3. Family planning services as established by § 1905(a)(4)(C) of the Social Security Act include annual family planning exams; cervical cancer screening for women; sexually transmitted infection (STI) testing; lab services for family planning and STI testing; family planning education, counseling, and preconception health; sterilization procedures; nonemergency transportation to a family planning service; and U.S. Food and Drug Administration approved prescription and over-the-counter contraceptives, subject to limits in 12VAC30-50-210.

12VAC30-60-65 Electronic visit verification

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Aide" means the person who is employed by an agency to provide hands-on care.

"Agency-directed services" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining an individual's records, and for scheduling the dates and times of the direct support staff's presence in the individual's home for personal care services, respite care services, and companion services.

"Attendant" means the person who is hired by the individual consumer to provide hands-on care.

"Companion services" means nonmedical care, supervision, and socialization provided to an adult individual (ages 18 years and older). The provision of companion services shall not entail hands-on care but shall be provided in accordance with a therapeutic goal in the individual support plan and is not purely diversional in nature.

"Consumer-directed attendant" means a person who provides consumer-directed personal care services, respite care services, companion services, or any combination of these three services, who is also exempt from workers' compensation.

"Consumer-directed services" or "CD services" means the model of service delivery for which the individual enrolled in the waiver or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of an attendant who renders the services that are reimbursed by DMAS.

"DMAS" means the Department of Medical Assistance Services.

"Electronic visit verification" or "EVV" means a system by which personal care services, companion services, or respite care services home visits are electronically verified with respect to (i) the type of service performed, (ii) the individual receiving the service, (iii) the date of the service, (iv) the location of service delivery, (v) the individual providing the service, and (vi) the time the service begins and ends.

"Individual" means the person who has applied for and been approved to receive services for which EVV is required.

"Personal care services" means a range of support services that includes assistance with activities of daily living and instrumental activities of daily living, access to the community, and self-administration of medication or other medical needs and the monitoring of health status and physical condition provided through the agency-directed or consumer-directed model of service. Personal care services shall be provided by a personal care attendant or aide within the scope of the attendant's or aide's license or certification, as appropriate.

"Respite care services" means services provided to waiver individuals who are unable to care for themselves that are furnished on a short-term basis because of the absence of or need for the relief of the unpaid primary caregiver who normally provides the care.

B. Applicable services. All of the requirements for an electronic visit verification system shall apply to all providers, both agency-directed and consumer-directed, of personal care services, respite care services, and companion services, unless exempt under Section C, below.

1. Agency providers shall choose the EVV system that best suits the provider business model, meets regulatory requirements established in this section, and provides reliable functionality for the geographic area in which it is to be used.

2. For consumer-directed services, the DMAS designee (the fiscal employer agent) shall select and operate an EVV system to support an individual, or the employer of record, in managing the individual's care, meeting regulatory requirements established in this section, and providing reliable functionality for the geographic area in which it is to be used.

3. Providers of consumer-directed personal care services, respite care services, and companion services shall comply with all EVV requirements.

4. Providers of agency-directed personal care services, respite care services, and companion services shall comply with all EVV requirements.

5. Individuals shall not be restricted from receiving a combination of agency-directed and consumer-directed services. Nothing in this section shall be construed to limit personal care, respite care, or companion services; an individual's selection of a provider attendant or aide; or impede the manner or location in which services are delivered subject to subsection C of this section.

C. The following entities and individuals shall be exempt from EVV requirements:

1. A DBHDS-licensed provider in a DBHDS-licensed program site, such as a group home or sponsored residential home or a supervised living, supported living, or similar facility or location licensed to provide respite care services;

2. The Regional Educational Assessment Crisis Response and Habilitation (REACH) Program;

3. Schools where personal care services are rendered under the authority of an individual education program; and

4. Live-in caregivers.

D. System requirements.

1. The EVV system shall be capable of capturing required data in real time and producing such data as requested by DMAS in electronic format. The following information shall be retained:

a. The type of the service being performed;

b. The individual who receives the service;

c. The date of the service, including month, day, and year;

d. The time the service begins and ends;

e. The location of the service delivery at the beginning and the end of the service. EVV systems shall not restrict locations where individuals may receive services; and

f. The attendant or aide who provides the service.

2. In the event the time of service delivery needs to be adjusted, the start or end time may be modified by someone who has the provider's authority to adjust the aide's or attendant's hours.

a. For agency-directed providers, this may be a supervisor or the agency owner or a designee who has authority to make independent verifications. In no case shall workers be allowed to adjust a peer worker's reported time.

b. For consumer-directed attendants, the fiscal employer agent shall have this authority.

3. All EVV systems shall be compliant with the requirements of the American with Disabilities Act (42 USC § 12101 et seq.) and Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

4. All EVV systems shall employ electronic devices that are capable of recording the required data described in subdivision D 1 of this section, producing it upon demand, and safeguarding the data both physically and electronically.

5. All EVV systems shall be accessible for input or service delivery 24 hours per day, seven days per week.

6. All EVV systems shall provide for data backups in the event of emergencies; disasters, natural or otherwise; and system malfunctions, both in the location services are being delivered and the backup server location.

7. All EVV systems shall be capable of handling:

a. Multiple work shifts per day per individual or aide or attendant combination;

b. Aides or attendants who work for multiple individuals;

c. Individuals who use multiple aides or attendants;

d. Multiple individuals and multiple aides or attendants or both in the same location at the same time and date. In such situations, the EVV shall be capable of separately documenting the services, as well as the other elements set out in subdivision D 1 of this section, that are provided to each individual; and

e. At minimum, daily backups of the most recent data that has been entered.

8. All EVV systems shall be capable of electronically transmitting information to DMAS in the required format or electronically transferring it to the provider's billing system.

E. EVV data shall be submitted to DMAS with the provider's billing claim, in a manner

that conforms with agency specifications.

F. Agency-directed provider records, audits, and reports.

1. Providers shall select and obtain an EVV system that meets the functional requirements of DMAS or its designee.

2. All providers shall retain EVV data for at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved. Policies regarding retention of records shall apply even if the provider discontinues operation.

a. In the event a provider discontinues services, DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise.

b. The location, agent, or trustee shall be within the Commonwealth.

3. All providers shall retain records of minor individuals for at least six years after such minor individual has reached 18 years of age.

4. All providers shall produce their archived EVV data in a timely manner and in an electronic format when requested by DMAS or its designee.

5. In the event that a telephone or other verification option that the provider uses is not available or accessible in the individual's home or location, and delayed data input is utilized, the provider shall have information on file documenting the reason that the aide or attendant did not use EVV for the service delivered.

12VAC30-120-766 Personal care and respite care services

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal care services means services offered to individuals in their homes and communities to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. This service shall provide care to individuals with activities of daily living (eating, drinking, personal hygiene, toileting, transferring, and ~~bowel/bladder~~ bowel or bladder control), instrumental

activities of daily living (IADL), access to the community, monitoring of self-medication or other medical needs, and the monitoring of health status or physical condition. In order to receive personal care services, the individual must require assistance with their ADLs. When specified in the plan of care, personal care services may include assistance with IADL. Assistance with IADL must be essential to the health and welfare of the individual, rather than the individual's ~~family/caregiver~~ family or caregiver. An additional component to personal care is work or school-related personal care. This allows the personal care provider to provide assistance and supports for individuals in the workplace and for those individuals attending postsecondary educational institutions. Workplace or school supports through the IFDDS Waiver are not provided if they are services that should be provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal care services cannot duplicate services provided under supported employment.

2. Respite care means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care.

3. Both agency-directed and consumer-directed personal care services and respite care services shall be subject to the requirements of electronic visit verification set out in 12VAC30-60-65.

B. Criteria.

1. In order to qualify for personal care services, the individual must demonstrate a need in activities of daily living, reminders to take medication, or other medical needs, or monitoring health status or physical condition.

2. In order to qualify for respite care, individuals must have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual.

3. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

1. The unit of service is one hour.

2. Effective July 1, 2011, respite care services are limited to a maximum of 480 hours per year. Individuals who are receiving services through both the agency-directed and consumer-directed models cannot exceed 480 hours per year combined.

3. Individuals may have personal care, respite care, and in-home residential support services in their plan of care but cannot receive in-home residential supports and personal care or respite care services at the same time.

4. Each individual receiving personal care services must have a back-up plan in case the personal care aide or consumer-directed (CD) employee does not show up for work as expected or terminates employment without prior notice.

5. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.

6. Individuals shall be permitted to share personal care service hours with one other individual (receiving waiver services) who lives in the same home.

7. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

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

1. Services shall be provided by:

a. For the agency-directed model, a DMAS enrolled personal care/respite care provider or by a DBHDS-licensed residential supportive in-home provider. All personal care aides must pass an objective standardized test of knowledge, skills, and abilities approved by DBHDS and administered according to DBHDS' defined procedures.

Providers must demonstrate a prior successful health care delivery business and operate from a business office.

b. For the consumer-directed model, a service facilitation provider meeting the requirements found in 12VAC30-120-770.

2. For DBHDS-licensed providers, a residential supervisor shall provide ongoing supervision for all personal care aides. For DMAS-enrolled personal care/respite care providers, the provider must employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all aides. The supervising RN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

3. The RN supervisor or case manager/services facilitator must make a home visit to conduct an initial assessment prior to the start of care for all individuals requesting services. The RN supervisor or case manager/service facilitator must also perform any subsequent reassessments or changes to the supporting documentation. Under the consumer-directed model, the initial comprehensive visit is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

4. The RN supervisor or case manager/services facilitator must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

a. For personal care the minimum frequency of these visits is every 30 to 90 calendar days depending on individual needs. For respite care offered on a routine basis, the minimum frequency of these visits is every 30 to 90 calendar days under the agency-directed model and every six months or upon the use of 240 respite care hours (whichever comes first) under the consumer-directed model.

b. Under the agency-directed model, when respite care services are not received on a routine basis, but are episodic in nature, the RN is not required to conduct a supervisory visit every 30 to 90 calendar days. Instead, the RN supervisor must conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.

c. When respite care services are routine in nature and offered in conjunction with personal care, the 30-day to 90-day supervisory visit conducted for personal care may serve as the RN supervisor or case manager/service facilitator visit for respite care. However, the RN supervisor or case manager/services facilitator must

document supervision of respite care separately. For this purpose, the same record can be used with a separate section for respite care documentation.

5. Under the agency-directed model, the supervisor shall identify any gaps in the aide's ability to provide services as identified in the individual's plan of care and provide training as indicated based on continuing evaluations of the aide's performance and the individual's needs.

6. The supervising RN or case manager/services facilitator must maintain current documentation. This may be done as a summary and must note:

a. Whether personal and respite care services continue to be appropriate;

b. Whether the supporting documentation is adequate to meet the individual's needs or if changes are indicated in the supporting documentation;

c. Any special tasks performed by the aide/CD employee and the aide's/CD employee's qualifications to perform these tasks;

d. Individual's satisfaction with the service;

e. Any hospitalization or change in the individual's medical condition or functioning status;

f. Other services received and their amount; and

g. The presence or absence of the aide in the home during the RN's visit.

7. Qualification of aides/CD employees. Each aide/CD employee must:

a. Be 18 years of age or older and possess a valid social security number;

b. For the agency-directed model, be able to read and write English to the degree necessary to perform the tasks required. For the consumer-directed model, possess basic math, reading and writing skills;

c. Have the required skills to perform services as specified in the individual's plan of care;

d. Not be the parents of individuals who are minors, or the individual's spouse. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the qualifications. In addition, under the consumer-directed model, ~~family/caregivers~~ family or caregivers acting as the employer on behalf of the individual may not also be the CD employee;

e. Additional aide requirements under the agency-directed model:

(1) Complete an appropriate aide training curriculum consistent with DMAS standards. Prior to assigning an aide to an individual, the provider must ensure that the aide has satisfactorily completed a training program consistent with DMAS standards. DMAS requirements may be met in any of the following ways:

(a) Registration as a certified nurse aide (DMAS-enrolled personal care/respite care providers);

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant or home health aide (DMAS-enrolled personal care/respite care providers);

(c) Completion of provider-offered training that is consistent with the basic course outline approved by DMAS (DMAS-enrolled personal care/respite care providers);

(d) Completion and passing of the DBHDS standardized test (DBHDS-licensed providers);

(2) Have a satisfactory work record as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

(3) Be evaluated in his job performance by the supervisor.

f. Additional CD employee requirements under the consumer-directed model:

(1) Submit to a criminal records check and, if the individual is a minor, the child protective services registry. The employee will not be compensated for services provided to the individual if the records check verifies the employee has been convicted of crimes described in § 37.2-314 of the Code of Virginia or if the employee has a complaint confirmed by the DSS child protective services registry;

(2) Be willing to attend training at the request of the individual or his ~~family/caregivers~~ family or caregiver, as appropriate;

(3) Understand and agree to comply with the DMAS consumer-directed services requirements; and

(4) Receive an annual TB screening.

8. Provider inability to render services and substitution of aides (agency-directed model). When an aide is absent, the provider may either obtain another aide, obtain a substitute aide 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 provider.

9. Retention, hiring, and substitution of employees (consumer-directed model). Upon the individual's request, the CD services facilitator shall provide the individual or his ~~family/caregiver~~ family or caregiver, as appropriate, with a list of consumer-directed employees on the consumer-directed employee registry that may provide temporary assistance until the employee returns or the individual or his ~~family/caregiver~~ family or caregiver, as appropriate, is able to select and hire a new employee. If an individual or his ~~family/caregiver~~ family or caregiver, as appropriate, is consistently unable to hire and retain an employee to provide consumer-directed services, the services facilitator must contact the case manager and DBHDS to transfer the individual, at the choice of the individual or his ~~family/caregiver~~ family or caregiver, as appropriate, to a provider that provides Medicaid-funded agency-directed personal care or respite care services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

10. Required documentation in individuals' records. The provider must maintain all records of each individual receiving services. Under the agency-directed model, these records must be separated from those of other nonwaiver services, such as home health services. At a minimum these records must contain:

a. The most recently updated plan of care and supporting documentation, all provider documentation, and all DMAS-225 forms;

b. Initial assessment by the RN supervisory nurse or case manager/services facilitator completed prior to or on the date services are initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse or case manager/services facilitator;

c. Nurses' or case manager/services facilitator summarizing notes recorded and dated during any contacts with the aide or CD employee and during supervisory visits to the individual's home;

d. All correspondence to the individual, to DBHDS, and to DMAS;

e. Contacts made with family, physicians, DBHDS, DMAS, formal and informal service providers, and all professionals concerning the individual;

f. Under the agency-directed model, all aide records. The aide record must contain:

(1) The specific services delivered to the individual by the aide and the individual's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered;

(4) The aide's and individual's weekly signatures to verify that services during that week have been rendered;

(5) Signatures, times, and dates; these signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered; and

(6) Copies of all aide records; these records shall be subject to review by state and federal Medicaid representatives.

g. Additional documentation requirements under the consumer-directed model:

(1) All management training provided to the individuals or their family caregivers, as appropriate, including responsibility for the accuracy of the timesheets.

(2) All documents signed by the individual or his ~~family/caregivers~~ family or caregiver, as appropriate, that acknowledge the responsibilities of the services.

12VAC30-120-924 Covered services; limits on covered services

A. Covered services in the EDCD Waiver shall include: adult day health care, personal care (both consumer-directed and agency-directed), respite services (both consumer-directed and agency-directed), PERS, PERS medication monitoring, limited assistive technology, limited environmental modifications, transition coordination, and transition services.

1. The services covered in this waiver shall be appropriate and medically necessary to maintain the individual in the community in order to prevent institutionalization and shall be cost effective in the aggregate as compared to the alternative NF placement.

2. EDCD services shall not be authorized if another entity is required to provide the services (e.g., schools, insurance). Waiver services shall not duplicate services available through other programs or funding streams.

3. Assistive technology and environmental modification services shall be available only to those EDCD Waiver individuals who are also participants in the Money Follows the Person (MFP) demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.).

4. An individual receiving EDCD Waiver services who is also getting hospice care may receive Medicaid-covered personal care (agency-directed and consumer-directed), respite care (agency-directed and consumer-directed), adult day health care, transition services, transition coordination, and PERS services, regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Such dual waiver/hospice

individuals shall only be able to receive assistive technology and environmental modifications if they are also participants in the MFP demonstration program.

5. Agency-directed and consumer-directed personal care services and respite care services shall be subject to the electronic visit verification requirements set out in 12VAC30-60-65.

B. ~~Voluntary/involuntary~~ Voluntary or involuntary disenrollment from consumer-directed services. In either voluntary or involuntary disenrollment situations, the waiver individual shall be permitted to select an agency from which to receive his agency-directed personal care and respite services.

1. A waiver individual may be found to be ineligible for CD services by either the Preadmission Screening Team, DMAS-enrolled hospital provider, DMAS, its designated agent, or the CD services facilitator. An individual may not begin or continue to receive CD services if there are circumstances where the waiver individual's health, safety, or welfare cannot be assured, including ~~but not limited to~~:

a. It is determined that the waiver individual cannot be the EOR and no one else is able to assume this role;

b. The waiver individual cannot ensure his own health, safety, or welfare or develop an emergency backup plan that will ensure his health, safety, or welfare; or

c. The waiver individual has medication or skilled nursing needs or medical or behavioral conditions that cannot be met through CD services or other services.

2. The waiver individual may be involuntarily disenrolled from consumer direction if he or the EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's timesheets.

3. In situations where either (i) the waiver individual's health, safety, or welfare cannot be assured or (ii) attendant timesheet discrepancies are known, the services facilitator shall assist as requested with the waiver individual's transfer to agency-directed services as follows:

a. Verify that essential training has been provided to the waiver individual or EOR;

b. Document, in the waiver individual's case record, the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator;

c. Discuss with the waiver individual or the EOR, as appropriate, the agency-directed option that is available and the actions needed to arrange for such services and offer choice of potential providers, and

d. Provide written notice to the waiver individual of the right to appeal such involuntary termination of consumer direction. Such notice shall be given at least 10 calendar days prior to the effective date of this change. In cases when the individual's or the provider personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.

C. Adult day health care (ADHC) services. ADHC services shall only be offered to waiver individuals who meet preadmission screening criteria as established in 12VAC30-60-303 and 12VAC30-60-307 and for whom ADHC services shall be an appropriate and medically necessary alternative to institutional care. ADHC services may be offered to individuals in a VDSS-licensed adult day care center (ADCC) congregate setting. ADHC may be offered either as the sole home and community-based care service or in conjunction with personal care (either agency-

directed or consumer-directed), respite care (either agency-directed or consumer-directed), or PERS. A multi-disciplinary approach to developing, implementing, and evaluating each waiver individual's POC shall be essential to quality ADHC services.

1. ADHC services shall be designed to prevent institutionalization by providing waiver individuals with health care services, maintenance of their physical and mental conditions, and coordination of rehabilitation services in a congregate daytime setting and shall be tailored to their unique needs. The minimum range of services that shall be made available to every waiver individual shall be: assistance with ADLs, nursing services, coordination of rehabilitation services, nutrition, social services, recreation, and socialization services.

a. Assistance with ADLs shall include supervision of the waiver individual and assistance with management of the individual's POC.

b. Nursing services shall include the periodic evaluation, at least every 90 days, of the waiver individual's nursing needs; provision of indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervision of the waiver individual in self-administered medication; support of families in their home care efforts for the waiver individuals through education and counseling; and helping families identify and appropriately utilize health care resources. Periodic evaluations may occur more frequently than every 90 days if indicated by the individual's changing condition. Nursing services shall also include the general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications.

c. Coordination and implementation of rehabilitation services to ensure the waiver individual receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include physical therapy, occupational therapy, and speech therapy.

d. Nutrition services shall be provided to include~~, but not necessarily be limited to,~~ one meal per day that meets the daily nutritional requirements pursuant to 22VAC40-60-800. Special diets and nutrition counseling shall be provided as required by the waiver individuals.

e. Recreation and social activities shall be provided that are suited to the needs of the waiver individuals and shall be designed to encourage physical exercise, prevent physical and mental deterioration, and stimulate social interaction.

f. ADHC coordination shall involve implementing the waiver individuals' POCs, updating such plans, recording 30-day progress notes, and reviewing the waiver individuals' daily logs each week.

2. Limits on covered ADHC services.

a. A day of ADHC services shall be defined as a minimum of six hours.

b. ADCCs that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing; or (iv) any other procedures that require sterile technique. The ADCC shall not permit its aide employees to perform skilled nursing procedures.

c. At any time that the center is no longer able to provide reliable, continuous care to any of the center's waiver individuals for the number of hours per day or days per week as contained in the individuals' POCs, then the center shall contact the waiver individuals or ~~family/caregivers~~ their family or caregivers, as appropriate, to initiate other care arrangements for these individuals. The center may either

subcontract with another ADCC or may transfer the waiver individual to another ADCC. The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge, at least 10 calendar days prior to the effective date of the discharge. In cases when the individual's or the center personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.

d. ADHC services shall not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in NFs, ICFs/IID, hospitals, assisted living facilities that are licensed by VDSS, or group homes that are licensed by DBHDS.

D. Agency-directed personal care services. Agency-directed personal care services shall only be offered to persons who meet the preadmission screening criteria at 12VAC30-60-303 and 12VAC30-60-307 and for whom it shall be an appropriate alternative to institutional care. Agency-directed personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include~~, but shall not necessarily be limited to,~~ assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and the monitoring of health status and physical condition. Where the individual requires assistance with ADLs, and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20. Agency-directed personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based care service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS. The provider shall document, in the individual's medical record, the waiver individual's choice of the agency-directed model.

1. Criteria. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-303 and 12VAC30-60-307 as documented on the UAI assessment form, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be needed if the waiver individual were receiving personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

c. The individual or ~~family/caregiver~~ family or caregiver shall have a backup plan for the provision of services in the event the agency is unable to provide an aide.

2. Limits on covered agency-directed personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. DMAS shall reimburse for services delivered, consistent with the approved POC, for personal care that the personal care aide provides to the waiver individual to assist him while he is at work or postsecondary school.

(1) DMAS or the designated Srv Auth contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that are provided to him in the workplace or postsecondary school or both.

(2) DMAS shall not pay for the personal care aide to assist the enrolled waiver individual with any functions or tasks related to the individual completing his job or postsecondary school functions or for supervision time during either work or postsecondary school or both.

c. Supervision services shall only be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no one else in the home competent and able to call for help in case of an emergency.

d. There shall be a maximum limit of eight hours per 24-hour day for supervision services. Supervision services shall be documented in the POC as needed by the individual.

e. Agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.

f. Electronic visit verification requirements set out in 12VAC30-60-65 shall apply to these agency-directed respite care services.

E. Agency-directed respite care services. Agency-directed respite care services shall only be offered to waiver individuals who meet the preadmission screening criteria at 12VAC30-60-303 and 12VAC30-60-307 and for whom it shall be an appropriate alternative to institutional care. Agency-directed respite care services may be either skilled nursing or unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include~~, but shall not be limited to,~~ assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and monitoring health status and physical condition.

1. Respite care shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. Respite care services may be provided in the individual's home or other community settings.

2. When the individual requires assistance with ADLs, and where such assistance is specified in the waiver individual's POC, such supportive services may also include assistance with IADLs.

3. The unskilled care portion of this service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20.

4. Limits on service.

a. The unit of service shall be one hour. Respite care services shall be limited to 480 hours per individual per state fiscal year, to be service authorized. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment for individuals who change waiver programs. Additionally, individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per state fiscal year combined.

b. If agency-directed respite care service is the only service received by the waiver individual, it must be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the provider agency shall notify the local department of social services for its redetermination of eligibility for the waiver individual.

c. The individual or ~~family/caregiver~~ family or caregiver shall have a backup plan for the provision of services in the event the agency is unable to provide an aide.

d. Electronic visit verification requirements set out in 12VAC30-60-65 shall apply to these agency-directed respite care services.

F. Services facilitation for consumer-directed services. Consumer-directed personal care and respite care services shall only be offered to persons who meet the preadmission screening criteria at 12VAC30-60-303 and 12VAC30-60-307 and for whom there shall be appropriate alternatives to institutional care.

1. Individuals who choose CD services shall receive support from a DMAS-enrolled CD services facilitator as required in conjunction with CD services. The services facilitator shall document the waiver individual's choice of the CD model and whether there is a need for another person to serve as the EOR on behalf of the individual. The CD services facilitator shall be responsible for assessing the waiver individual's particular needs for a requested CD service, assisting in the development of the POC, providing training to the EOR on his responsibilities as an employer, and for providing ongoing support of the CD services.

2. Individuals who are eligible for CD services shall have, or have an EOR who has, the capability to hire and train the personal care attendant or attendants and supervise the attendant's performance, including approving the attendant's timesheets.

a. If a waiver individual is unwilling or unable to direct his own care or is younger than 18 years of age, ~~a family/caregiver/designated~~ family, a caregiver, or a designated person shall serve as the EOR on behalf of the waiver individual in order to perform these supervisory and approval functions.

b. Specific employer duties shall include checking references of personal care attendants and determining that personal care attendants meet qualifications.

3. The individual or ~~family/caregiver~~ family or caregiver shall have a backup plan for the provision of services in case the attendant does not show up for work as scheduled or terminates employment without prior notice.

4. The CD services facilitator shall not be the waiver individual, a CD attendant, a provider of other Medicaid-covered services, spouse of the individual, parent of the individual who is a minor child, or the EOR who is employing the CD attendant.

5. DMAS shall either provide for fiscal employer/agent services or contract for the services of a fiscal employer/agent for CD services. The fiscal employer/agent shall be reimbursed by DMAS or DMAS contractor (if the fiscal/employer agent service is contracted) to perform certain tasks as an agent for the EOR. The fiscal employer/agent shall handle responsibilities for the waiver individual including~~, but not limited to,~~ employment taxes and background checks for attendants. The fiscal employer/agent shall seek and obtain all necessary authorizations and approvals of the Internal Revenue Service in order to fulfill all of these duties.

G. Consumer-directed personal care services. CD personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include assistance with ADLs and may include~~, but shall not be limited to,~~access to the community, monitoring of self-administered medications or other medical needs, supervision, and monitoring health status and physical condition.

Where the waiver individual requires assistance with ADLs and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g. catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC 90-20 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. CD personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS.

1. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-303 and 12VAC30-60-307 as documented on the UAI assessment instrument, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the waiver individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be otherwise authorized had the individual chosen to receive personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

2. Limits on covered CD personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. There shall be a limit of eight hours per 24-hour day for supervision services included in the POC. Supervision services shall be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no one else in the home who is competent and able to call for help in case of an emergency.

c. Consumer-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.

d. Electronic visit verification requirements as set out in 12VAC30-60-65 shall apply to these CD personal care services.

3. CD personal care services at work or school shall be limited as follows:

a. DMAS shall reimburse for services delivered, consistent with the approved POC, for CD personal care that the attendant provides to the waiver individual to assist him while he is at work or postsecondary school or both.

b. DMAS or the designated Srv Auth contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to him in the workplace or postsecondary school or both.

c. DMAS shall not pay for the personal care attendant to assist the waiver individual with any functions or tasks related to the individual completing his job or postsecondary school functions or for supervision time during work or postsecondary school or both.

H. Consumer-directed respite care services. CD respite care services are unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include~~, but shall not be limited to,~~ assistance with ADLs, access to the community, monitoring of self-administration of medications or other medical needs, supervision, monitoring health status and physical condition, and personal care services in a work environment.

1. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-303 and 12VAC30-60-307 as documented on the UAI assessment instrument, and for whom it shall be an appropriate alternative to institutional care.

2. CD respite care services shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. This service shall be provided in the waiver individual's home or other community settings.

3. When the waiver individual requires assistance with ADLs, and where such assistance is specified in the individual's POC, such supportive services may also include assistance with IADLs.

4. Electronic visit verification requirements as set out in 12VAC30-60-65 shall apply to these CD respite care services.

5. Limits on covered CD respite care services.

a. The unit of service shall be one hour. Respite care services shall be limited to 480 hours per waiver individual per state fiscal year. If a waiver individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per state fiscal year combined.

b. CD respite care services shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia).

c. If consumer-directed respite care service is the only service received by the waiver individual, it shall be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the services facilitator shall refer the waiver individual to the local department of social services for its redetermination of eligibility for the waiver individual.

I. Personal emergency response system (PERS).

1. Service description. PERS is a service that monitors waiver individual safety in the home and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line or system. PERS may also include medication monitoring devices.

a. PERS may be authorized only when there is no one else in the home with the waiver individual who is competent or continuously available to call for help in an emergency or when the individual is in imminent danger.

b. The use of PERS equipment shall not relieve the backup caregiver of his responsibilities.

c. Service units and service limitations.

(1) PERS shall be limited to waiver individuals who are ages 14 years and older who also either live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time. PERS shall only be provided in conjunction with receipt of personal care services (either agency-directed or consumer-directed), respite services (either agency-directed or consumer-directed), or adult day health care. A waiver individual shall not receive PERS if he has a cognitive impairment as defined in 12VAC30-120-900.

(2) A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service shall be the one-month rental price set by DMAS in its fee schedule. The one-time installation of the unit shall include installation, account activation, individual and ~~family/caregiver~~ family or caregiver instruction, and subsequent removal of PERS equipment when it is no longer needed.

(3) PERS services shall be capable of being activated by a remote wireless device and shall be connected to the waiver individual's telephone line or system. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be (i) waterproof, (ii) able to automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, (iii) able to be worn by the waiver individual, and (iv) automatically reset by the response center after each activation, thereby ensuring that subsequent signals can be transmitted without requiring manual resetting by the waiver individual.

(4) All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard.

(5) Medication monitoring units shall be physician ordered. In order to be approved to receive the medication monitoring service, a waiver individual shall also receive PERS services. Physician orders shall be maintained in the waiver individual's record. In cases where the medical monitoring unit must be filled by the provider, the person who is filling the unit shall be either an RN or an LPN. The units may be filled as frequently as a minimum of every 14 days. There must be documentation of this action in the waiver individual's record.

J. Transition coordination and transition services. Transition coordination and transition services, as defined at 12VAC30-120-2000 and 12VAC30-120-2010, provide for applicants to move from institutional placements or licensed or certified provider-operated living arrangements to private homes or other qualified settings. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall coordinate with the transition coordinator to ensure that EDCD Waiver eligibility criteria shall be met.

1. Transition coordination and transition services shall be authorized by DMAS or its designated agent in order for reimbursement to occur.

2. For the purposes of transition services, an institution must meet the requirements as specified by CMS in the Money Follows the Person demonstration program at **http://www.ssa.gov/OP_Home/comp2/F109-171.html#ft262**.

3. Transition coordination shall be authorized for a maximum of 12 consecutive months upon discharge from an institutional placement and shall be initiated within 30 days of discharge from the institution.

4. Transition coordination and transition services shall be provided in conjunction with personal care (agency-directed or consumer-directed), respite care (agency-

directed or consumer-directed), or adult day health care services.

K. Assistive technology (AT).

1. Service description. Assistive technology (AT), as defined in 12VAC30-120-900, shall only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.).

2. In order to qualify for these services, the individual shall have a demonstrated need for equipment for remedial or direct medical benefit primarily in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. AT shall be covered in the least expensive, most cost-effective manner.

3. Service units and service limitations.

a. All requests for AT shall be made by the transition coordinator to DMAS or the Srv Auth contractor.

b. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be $5,000 per year for individuals regardless of waiver, or regardless of whether the individual changes waiver programs, for which AT is approved. The service unit shall always be one, for the total cost of all AT being requested for a specific timeframe.

c. AT may be provided in the individual's home or community setting.

d. AT shall not be approved for purposes of convenience of the ~~caregiver/provider~~caregiver or provider or restraint of the individual.

e. An independent, professional consultation shall be obtained from a qualified professional who is knowledgeable of that item for each AT request prior to approval by the Srv Auth contractor and may include training on such AT by the qualified professional. The consultation shall not be performed by the provider of AT to the individual.

f. All AT shall be prior authorized by the Srv Auth contractor prior to billing.

g. Excluded shall be items that are reasonable accommodation requirements, for example, of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), or the Rehabilitation Act (20 USC § 794) or that are required to be provided through other funding sources.

h. AT services or equipment shall not be rented but shall be purchased.

L. Environmental modifications (EM).

1. Service description. Environmental modifications (EM), as defined herein, shall only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.). Adaptations shall be documented in the waiver individual's POC and may include~~, but shall not necessarily be limited to,~~ the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the waiver individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, flooring, roof repairs, central air conditioning, or decks. Adaptations that add to the total square footage of the home shall be excluded from this benefit,

except when necessary to complete an authorized adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications must be prior authorized by the Srv Auth contractor. Modifications may only be made to a vehicle if it is the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles.

2. In order to qualify for these services, the waiver individual shall have a demonstrated need for modifications of a remedial or medical benefit offered in his primary home or primary vehicle used by the waiver individual to ensure his health, welfare, or safety or specifically to improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. EM shall be covered in the least expensive, most cost-effective manner.

3. Service units and service limitations.

a. All requests for EM shall be made by the MFP transition coordinator to DMAS or the Srv Auth contractor.

b. The maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be $5,000 per year for individuals regardless of waiver, or regardless of whether the individual changes waiver programs, for which EM is approved. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

c. All EM shall be authorized by the Srv Auth contractor prior to billing.

d. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794).

e. Transition coordinators shall, upon completion of each modification, meet face-to-face with the waiver individual and his ~~family/caregiver~~ family or caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual.

f. EM shall not be approved for purposes of convenience of the ~~caregiver/provider~~caregiver or provider or restraint of the waiver individual.

12VAC30-120-930 General requirements for home and community-based participating providers

A. Requests for participation shall be screened by DMAS or the designated DMAS contractor to determine whether the provider applicant meets the requirements for participation, as set out in the provider agreement, and demonstrates the abilities to perform, at a minimum, the following activities:

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal health care programs, including Medicaid (i.e., via the United States Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219, or email to providerexclusions@dmas.virginia.gov;

2. Immediately notify DMAS in writing of any change in the information that the provider previously submitted to DMAS;

3. Except for waiver individuals who are subject to the DMAS Client Medical Management program Part VIII (12VAC30-130-800 et seq.) of 12VAC30-130 or are enrolled in a Medicaid managed care program, ensure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the ~~service or~~ services required and participating in the Medicaid Program at the time the ~~service or~~ services are performed;

4. Ensure the individual's freedom to refuse medical care, treatment, and services;

5. Accept referrals for services only when staff is available to initiate and perform such services on an ongoing basis;

6. Provide services and supplies to individuals in full compliance with Title VI (42 USC § 2000d et seq.) of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973 (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990 (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;

7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as are provided to the general public;

8. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS payment methodology beginning with the individual's authorization date for the waiver services;

9. Use only DMAS-designated forms for service documentation. The provider shall not alter the DMAS forms in any manner without prior written approval from DMAS;

10. Use DMAS-designated billing forms for submission of charges;

11. Perform no type of direct marketing activities to Medicaid individuals;

12. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

a. In general, such records shall be retained for a period of at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for a period of at least six years after such minor has reached 18 years of age.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth;

13. Furnish information on the request of and in the form requested to DMAS, the Attorney General of Virginia or their authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement;

14. 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 recipients of Medicaid;

15. Pursuant to 42 CFR 431.300 et seq., § 32.1-325.3 of the Code of Virginia, and the Health Insurance Portability and Accountability Act (HIPAA), safeguard and hold confidential all information associated with an applicant or enrollee or individual that could disclose the ~~applicant's/enrollee's/individual's~~ applicant's, enrollee's, or individiual's identity. Access to information concerning the ~~applicant/enrollee/individual~~ applicant, enrollee, or individual shall be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency and any such access must be in accordance with the provisions found in 12VAC30-20-90;

16. When ownership of the provider changes, notify DMAS in writing at least 15 calendar days before the date of change;

17. Pursuant to §§ 63.2-100, 63.2-1509, and 63.2-1606 of the Code of Virginia, if a participating provider or the provider's staff knows or suspects that a home and community-based waiver services individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge or suspicion of such knowledge to the local department of social services adult or child protective services worker as applicable or to the toll-free, 24-hour hotline as described on the local department of social services' website. Employers shall ensure and document that their staff is aware of this requirement;

18. In addition to compliance with the general conditions and requirements, adhere to the conditions of participation outlined in the individual provider's participation agreements, in the applicable DMAS provider manual, and in other DMAS laws, regulations, and policies. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures may result in a retraction of Medicaid payment or termination of the provider agreement, or both;

19. Meet minimum qualifications of staff.

a. For reasons of Medicaid individuals' safety and welfare, all employees shall have a satisfactory work record, as evidenced by at least two references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children. In instances of employees who have worked for only one employer, such employees shall be permitted to provide one appropriate employment reference and one appropriate personal reference including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children.

b. Criminal record checks for both employees and volunteers conducted by the Virginia State Police. Proof that these checks were performed with satisfactory results shall be available for review by DMAS staff or its designated agent who are authorized by the agency to review these files. DMAS shall not reimburse the provider for any services provided by an employee or volunteer who has been convicted of committing a barrier crime as defined in § 32.1-162.9:1 of the Code of Virginia. Providers shall be responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. Provider staff shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the criminal record check confirms the provider's staff person or volunteer was convicted of a barrier crime.

c. Provider staff and volunteers who serve waiver individuals who are minor children shall also be screened through the VDSS Child Protective Services (CPS) Central Registry. Provider staff and volunteers shall not be reimbursed for services

provided to the waiver individual effective on the date and thereafter that the VDSS CPS Central Registry check confirms the provider's staff person or volunteer has a finding.

20. Comply with the electronic visit verification requirements set out in 12VAC30-60-65.

B. DMAS shall terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories shall within 30 days of such conviction notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations, subject to applicable appeal rights, shall conform to § 32.1-325 D and E of the Code of Virginia and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

C. For DMAS to approve provider agreements with home and community-based waiver providers, the following standards shall be met:

1. Staffing, financial solvency, disclosure of ownership, and ensuring comparability of services requirements as specified in the applicable provider manual;

2. The ability to document and maintain waiver individuals' case records in accordance with state and federal requirements;

3. Compliance with all applicable laws, regulations, and policies pertaining to EDCD Waiver services.

D. The waiver individual shall have the option of selecting the provider of his choice from among those providers who are approved and who can appropriately meet his needs.

E. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification to DMAS.

F. DMAS may terminate at will a provider's participation agreement on 30 days' written notice as specified in the DMAS participation agreement. DMAS may immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the Medicaid program. Such action precludes further payment by DMAS for services provided to individuals on or after the date specified in the termination notice.

G. The provider shall be responsible for completing the DMAS-225 form. The provider shall notify the designated Srv Auth contractor, as appropriate, and the local department of social services, in writing, when any of the following events occur. Furthermore, it shall be the responsibility of the designated Srv Auth contractor to also update DMAS, as requested, when any of the following events occur:

1. Home and community-based waiver services are implemented;

2. A waiver individual dies;

3. A waiver individual is discharged from the provider's EDCD Waiver services;

4. Any other events (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 consecutive calendar days; or

5. The initial selection by the waiver individual or ~~family/caregiver~~ family or caregiver of a provider to provide services, or a change by the waiver individual

or ~~family/caregiver~~ family or caregiver of a provider, if it affects the individual's patient pay amount.

H. Changes or termination of services.

1. The provider may decrease the amount of authorized care if the revised POC is appropriate and based on the medical needs of the waiver individual. The participating provider shall collaborate with the waiver individual or the ~~family/caregiver/EOR~~ family, caregiver, or EOR, or both as appropriate, to develop the new POC and calculate the new hours of service delivery. The provider shall discuss the decrease in care with the waiver individual or ~~family/caregiver/EOR~~family, caregiver, or EOR, document the conversation in the waiver individual's record, and notify the designated Srv Auth contractor. The Srv Auth contractor shall process the decrease request and the waiver individual shall be notified of the change by letter. This letter shall clearly state the waiver individual's right to appeal this change.

2. If a change in the waiver individual's condition necessitates an increase in care, the participating provider shall assess the need for the increase and, collaborate with the waiver individual and ~~family/caregiver/EOR~~ family, caregiver, or EOR, as appropriate, to develop a POC for services to meet the changed needs. The provider may implement the increase in ~~personal/respite~~ personal care or respitecare hours without approval from DMAS, or the designated Srv Auth contractor, if the amount of services does not exceed the total amount established by DMAS as the maximum for the level of care designated for that individual on the plan of care.

3. Any increase to a waiver individual's POC that exceeds the number of hours allowed for that individual's level of care or any change in the waiver individual's level of care shall be authorized by DMAS or the designated Srv Auth contractor prior to the increase and be accompanied by adequate documentation justifying the increase.

4. In an emergency situation when either the health, safety, or welfare of the waiver individual or provider personnel is endangered, or both, DMAS, or the designated Srv Auth contractor, shall be notified prior to discontinuing services. The written notification period set out below shall not be required. If appropriate, local department of social services adult or child protective services, as may be appropriate, shall be notified immediately. Appeal rights shall be afforded to the waiver individual.

5. In a nonemergency situation, when neither the health, safety, nor welfare of the waiver individual or provider personnel is endangered, the participating provider shall give the waiver individual at least 10 calendar days' written notification (plus three days for mail transit for a total of 13 calendar days from the letter's date) of the intent to discontinue services. The notification letter shall provide the reasons for and the effective date the provider will be discontinuing services. Appeal rights shall be afforded to the waiver individual.

I. Staff education and training requirements.

1. RNs shall (i) be currently licensed to practice in the Commonwealth as an RN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or NF, or as an LPN who worked for at least one year in one of these settings; and (iii) submit to a criminal records check and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The RN shall not be compensated for services provided to the waiver individual if this record check

verifies that the RN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the RN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

2. LPNs shall work under supervision as set out in 18VAC90-20-37. LPNs shall (i) be currently licensed to practice in the Commonwealth as an LPN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) shall have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or NF. The LPN shall meet the qualifications and skills, prior to being assigned to care for the waiver individual, that are required by the individual's POC; and (iii) submit to a criminal records check and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The LPN shall not be compensated for services provided to the waiver individual if this record check verifies that the LPN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the LPN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

3. Personal care aides who are employed by personal care agencies that are licensed by VDH shall meet the requirements of 12VAC5-381. In addition, personal care aides shall also receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services.

4. Personal care aides who are employed by personal care agencies that are not licensed by the VDH shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities, as ensured by the provider prior to being assigned to the care of an individual, and shall have the required skills and training to perform the services as specified in the waiver individual's POC and related supporting documentation.

a. Personal care aides' required initial (that is, at the onset of employment) training, as further detailed in the applicable provider manual, shall be met in one of the following ways: (i) registration with the Board of Nursing as a certified nurse aide; (ii) graduation from an approved educational curriculum as listed by the Board of Nursing; or (iii) completion of the provider's educational curriculum, which must be a minimum of 40 hours in duration, as taught by an RN who meets the same requirements as the RN listed in subdivision 1 of this subsection.

b. In addition, personal care aides shall also be required to receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services.

5. Personal care aides shall:

a. Be at least 18 years of age or older;

b. Be able to read and write English to the degree necessary to perform the expected tasks and create and maintain the required documentation;

c. 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;

d. Have a valid social security number that has been issued to the personal care aide by the Social Security Administration;

e. Submit to a criminal records check and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. The aide shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the aide has been

convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the aide has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;

f. Understand and agree to comply with the DMAS EDCD Waiver requirements; and

g. Receive tuberculosis (TB) screening as specified in the criteria used by the VDH.

6. Consumer-directed personal care attendants shall:

a. Be 18 years of age or older;

b. Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required documentation;

c. Be physically able to perform the required tasks and have the required skills to perform consumer-directed services as specified in the waiver individual's supporting documentation;

d. Have a valid social security number that has been issued to the personal care attendant by the Social Security Administration;

e. Submit to a criminal records check and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. The attendant shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the attendant has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the attendant has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;

f. Understand and agree to comply with the DMAS EDCD Waiver requirements;

g. Receive tuberculosis (TB) screening as specified in the criteria used by the VDH; and

h. Be willing to attend training at the individual's or ~~family/caregiver's~~ family or caregiver's request.

12VAC30-122-125 Electronic visit verification

A. Except as specified in subsection B of this section, the requirements of 12VAC30-60-65 shall apply for personal care services, respite care services, and companion services.

B. EVV requirements shall not apply to respite care services provided by a DBHDS-licensed provider in a DBHDS-licensed program site, such as a group home or sponsored residential home or a supervised living, supported living, or similar facility or location licensed to provide respite care services as permitted by the Centers for Medicare and Medicaid Services.