PART .
MENTAL RETARDATION WAIVER
Subpart 1.

12VAC30-120-210. Definitions. This regulation shall only apply to those individuals who are receiving congregate residential services in DSS-licensed assisted living facilities that are seeking DMHMRSAS licensure pursuant to 12 VAC 30-120-230(C). This regulation shall only be in effect through September 15, 2002.

The following words and terms as used in this part shall have the following meanings unless the context indicates otherwise:

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

"Case management" means the assessment, planning, linking and monitoring for individuals referred for mental retardation community-based care waiver services. Case management (i) ensures the development, coordination, implementation, monitoring, and modification of the individual service plan; (ii) links the individual with appropriate community resources and supports; (iii) coordinates service providers; and (iii) monitors quality of care.

"Case managers" means individuals possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses the knowledge, skills and abilities, as established by DMHMRSAS, necessary to perform case management services.

"Community based care waiver services" or "waiver services" means the range of community support services approved by the Health Care Financing Administration pursuant to §1915(c) of the Social Security Act to be offered to mentally retarded and developmentally disabled individuals who would otherwise require the level of care provided in an intermediate care facility for the mentally retarded.

"Community services board" or "CSB" means the public organization authorized by the Code of Virginia to provide services to individuals with mental illness or retardation, operating autonomously but in partnership with the DMHMRSAS.

"Consumer Service Plan" or "CSP" means that document addressing the needs of the recipient of home and community-based care mental retardation services, in all life areas. The Individual Service Plans developed by service providers are to be incorporated in the CSP by the case

manager. Factors to be considered when this plan is developed may include, but are not limited to, the recipient's age, primary disability, and level of functioning.

"Crisis stabilization" means direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral problems, or both, which jeopardize their current community living situation by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional admission or prevent other out of home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so that the individual can be maintained in the community during and beyond the crisis period. Services will include, as appropriate, psychiatric, neuropsychiatric, and psychological assessment and other functional assessments and stabilization techniques; medication management and monitoring; behavior assessment and positive behavioral support; intensive care coordination with other agencies and providers to assist planning and delivery of services and supports to maintain community placement of the recipient; training of family members, other care givers, and service providers in positive behavioral supports to maintain the individual in the community; and temporary crisis supervision to ensure the safety of the individual and others.

"DMAS" means the Department of Medical Assistance Services.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMHMRSAS staff" means individuals employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services to perform utilization review, recommendation of preauthorization for service type and intensity, and review of individual level of care criteria.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self-care, physical development, transportation to and from training sites, services and support activities, and prevocational services aimed at preparing an individual for paid or unpaid employment.

"Developmental risk" means the presence before, during or after an individual's birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through diagnostic and evaluative criteria.

"Environmental modifications" means physical adaptations to a house, place of residence, vehicle, or work site, when the modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by the Department of Medical Assistance Services for children under the age of 21 according to federal guidelines which prescribe specific preventive and treatment services for Medicaid-eligible children.

"HCFA" means the Health Care Financing Administration as that unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

"Individual Service Plan" or "ISP" means the service plan developed by the individual service provider related solely to the specific tasks required of that service provider. ISPs help to comprise the overall Consumer Service Plan of care for the individual. The ISP is defined in DMHMRSAS licensing regulations 12VAC35-102-10 et seq.

"Mental retardation" means the diagnostic classification of substantial subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

"Nursing services" means skilled nursing services listed in the plan of care which are ordered by a physician and required to prevent institutionalization, not available under the State Plan for Medical Assistance, are within the scope of the state's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the state.

"Personal assistance" means assistance with activities of daily living, medication and/or other medical needs and monitoring health status and physical condition for individuals who do not receive residential support services and for whom training and skills development are not primary objectives or are provided through another program or service.

"Persons with related conditions served by this waiver" means persons residing in nursing facilities who have been determined through annual resident review to require specialized services and who, consistent with 42 CFR 435.1009, are individuals who have severe, chronic disabilities that meet all of the following conditions:

1. It is attributable to:

a. Cerebral palsy or epilepsy; or

b. Any other condition other than mental illness found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job or task oriented but focus on goals such as attention span and motor skills. Compensation, if provided, would be for persons whose productivity is less than 50% of the minimum wage.

"Qualified mental retardation professional" means individuals possessing (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, and psychology; and (iii) the required Virginia or national license, registration or certification in accordance with his profession.

"Residential support services" means support provided in a licensed or certified residence or in the individual's home. This service is one in which support and supervision is routinely provided. Support includes training, assistance, and supervision in enabling individuals to maintain or improve their health, to develop skills in activities of daily living, and safety, in the use of community resources, and adapting their behavior to community and home-like environments. Reimbursement for residential support shall not include the cost of room, board, and general supervision.

"Respite care" means services given to individuals unable to care for themselves provided on a short-term basis because of the absence or need for relief of those persons normally providing the care.

"State Plan for Medical Assistance" or "Plan" means the regulations identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supported employment" means training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized supervision to enable a consumer to maintain paid employment provided to mentally retarded individuals.

"Therapeutic consultation" means consultation provided by members of psychology, social work, behavioral analysis, speech therapy, occupational therapy, therapeutic recreation, physical therapy disciplines, or behavior consultation to assist the individual, parents/family members, Part H early intervention providers, residential support, day support and any other providers of support services in implementing an individual service plan.

12VAC30-120-211. Definitions.

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

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

"CMS" means the Center for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services, which administers the Medicare and Medicaid programs.

"Case management" means the assessment, planning, linking, and monitoring for individuals referred for mental retardation community-based care waiver services. Case management: (i) ensures the development, coordination, implementation, monitoring, and modification of the individual service plan; (ii) links individuals with appropriate community resources and supports; (iii) coordinates service providers; and (iv) monitors quality of care.

"Case managers" means individuals possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses the knowledge, skills and abilities, as established by DMHMRSAS, necessary to perform case management services.

"Community-based care waiver services" or "waiver services" means the range of community support services approved by the Center for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to persons with mental retardation and children younger than age 6 who are at developmental risk who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR.)

"Community services board" or "CSB" means the public organization authorized by the Code of Virginia to provide services to individuals with mental illness or retardation, operating autonomously but in partnership with DMHMRSAS.

"Companion aide" means, for the purpose of these regulations, a domestic servant who is also exempt from Worker's Compensation.

"Companion services" means non-medical care, supervision and socialization, provided to an adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert individuals from institutional care.

"Consumer-directed attendant care/personal assistance" means hands-on care, of both a supportive and health-related nature. The individual will be responsible for hiring, training, supervising, and firing the personal assistant. If the individual is unable to independently manage his own assistant care, a family caregiver may serve as the employer on behalf of the individual.

"Consumer-directed companion care" means non-medical care, supervision, and socialization, provided to an adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert individuals from institutional care. The individual will be responsible for hiring, training, supervising, and firing the personal assistant. If the individual is unable to independently manage his own consumer-directed companion care, a family caregiver can serve as the employer on behalf of the individual.

"Consumer-directed respite care" means services given to caretakers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence or need for relief of those caretakers-residing-with-the-individual who normally provide the care. The individual will be responsible for hiring, training, supervising, and firing the personal assistant. If the individual is unable to independently manage his own consumer-directed respite care, a family caregiver can serve as the employer on behalf of the individual.

"Consumer directed (CD) Services Facilitator" means the provider contracted with DMAS that is responsible for ensuring development and monitoring of the Consumer Service Plan, management training, and review activities as required by DMAS for consumer-directed companion, personal assistance, and respite care services.

"Consumer service plan" or "CSP" means that document addressing all needs of individuals who receive home and community-based care mental retardation services, in all life areas, and is comprised of several various Individual Service Plans as dictated by the individual's health care and support needs. The Individual Service Plans developed by service providers are to be incorporated in the CSP by the case manager. Factors to be considered when these plans are developed may include, but are not limited to, individual's ages and levels of functioning.

"Crisis stabilization" means direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral problems, or both, that jeopardize their current community living situation by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out of home placement. This service shall be designed to stabilize individuals and strengthen the current living situations so that individuals can be

maintained in the community during and beyond the crisis period. Services will include, as appropriate, psychiatric, neuropsychiatric, and psychological assessment and other functional assessments and stabilization techniques; medication management and monitoring; behavior assessment and positive behavioral support; intensive care coordination with other agencies and providers to assist planning and delivery of services and supports to maintain community placement of the individual; training of family members, other care givers, and service providers in positive behavioral supports to maintain the individual in the community; and temporary crisis supervision to ensure the safety of the individual and others.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means individuals hired by the Department of Medical Assistance Services who perform utilization review, or other DMAS personnel.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMHMRSAS staff" means individuals employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services to pre-authorize services and review of individual level of care criteria.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, transportation to and from training sites, services and support activities.

"Developmental risk" means the presence before, during or after an individual's birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Environmental modifications" means physical adaptations to a house, place of residence, vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines which prescribe preventive and treatment services for Medicaid-eligible children.

"Fiscal agent" means an agency or organization within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal assistance, respite, and companion services.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS as authorized under the Social Security Act § 1915(c) waiver designed to offer individuals alternatives to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services in order to avoid ICF/MR placement.

"ICF/MR" means a facility or distinct part of another facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an intermediate care facility for the mentally retarded and persons with related conditions. These facilities must address the total needs of the residents which include physical, intellectual, social, emotional, and habilitation and must provide active treatment.

"Immediate family" means spouse, parents, legal guardians, siblings, children, grandparents, and grandchildren.

"Individual" means the person receiving the services and evaluations established in these regulations.

"Individual Service Plan" or "ISP" means the service plan developed by the specific service provider related solely to the specific tasks required of that service provider. Multiple ISPs help to comprise the overall Consumer Service Plan of care for the individual. The ISP is defined in DMHMRSAS licensing regulations 12 VAC35-102-10 et seq.

"Instrumental Activities of Daily Living or IADLs" means social tasks, i.e., meal preparation, shopping, housekeeping, laundry, and money management.

"Mental retardation or MR" means, in accordance with the American Association on Mental Retardation (AAMR), being substantially limited in present functioning that is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70-75 or below, as diagnosed by a licensed clinical professional; and there are related limitations in two or more applicable adaptive skill areas; and the age of onset is 18 or below. If a valid IQ score is not possible, significantly sub-average intellectual capabilities means a level of performance that is less than that observed in the vast majority of persons of comparable background. In order to be valid, the assessment of the intellectual performance must be free from errors caused by motor, sensory, emotional, language, or cultural factors.

"Nursing services" means skilled nursing services listed in the plan of care which are ordered by a physician and required to prevent institutionalization, not otherwise available under the State Plan for Medical Assistance, are within the scope of the Chapters 30 and 34 of Subtitle III of Title 54.1 of the Code of Virginia, and are provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the Commonwealth.

"Part C" means 20 USC 1431 Part 303 et. seq.

"Participating provider" means an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and DMHMRSAS, and has a current, signed contract with DMAS.

"Personal assistant" means, for purposes of this regulation, a domestic servant who is also exempt from Worker's Compensation.

"Personal assistance" means assistance with activities of daily living, medication, or other medical needs and the monitoring of health status and physical condition for individuals who do not receive residential support services and for whom training and skills development are not primary objectives or are provided through another program or service.

"Personal emergency response system (PERS)" is a device that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job or task oriented but focus on goals such as attention span and motor skills. Compensation, if provided, would be for persons whose productivity is less than 50% of the minimum wage.

"Qualified mental retardation professional" means a professional possessing: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

"Residential support services" means support provided in a licensed residence or in the individual's home. This service is one in which training, assistance, and specialized supervision is routinely provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living, and safety, in the use of community resources, and adapting their behavior to community and home-like environments. Reimbursement for residential support shall not include the cost of room, board, and general supervision.

"Respite care" means services specifically designed to provide a temporary but periodic or routine relief to the primary unpaid caregiver of an individual who is incapacitated or dependent due to disability.

"Screening" means the process to: evaluate the medical and social needs of individuals referred for evaluation, determine Medicaid eligibility for an ICF/MR level of care and authorize Medicaid-funded ICF/MR care or community-based care for those individuals who meet ICF/MR level of care and require that level of care.

"State Plan for Medical Assistance" or "Plan" means the regulations identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supported employment" means training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment which may be provided to individuals with mental retardation.

"Therapeutic consultation" means consultation provided by members of the disciplines of psychology, social work, behavioral consultation, speech therapy, occupational therapy, therapeutic recreation, physical therapy or behavior consultation to assist the individual, parents and family members, Part C early intervention providers, residential support, day support and any other providers of support services in implementing an individual service plan.

12VAC30-120-212. General coverage and requirements for all home and community-based care waiver services.

A. Waiver service populations. Home and community-based services shall be available through a §1915(c) waiver for the following individuals who have been determined to require the level of care provided in an ICF/MR.

1. Individuals with mental retardation.

2. Individuals younger than the age of six who are at developmental risk. At the age of six years, these individuals must be determined to be mentally retarded to continue to receive home and community-based care services specifically under this program.

B. Covered services.

1. Covered services shall include: residential support services, day support, supported employment, personal assistance (both consumer and agency-directed), respite care (both agency- and consumer-directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, prevocational services,

personal emergency response systems (PERS), and companion care (both consumer and agency-directed.)

2. These services shall be clinically appropriate and necessary to maintain these individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in Intermediate Care Facilities for the Mentally Retarded under the State Plan that would have been provided had the waiver not been granted.

3. Under this § 1915(c) waiver, DMAS waives the Social Security Act § 1902(a)(10)(B) of Act related to comparability.

C. All requests for increased services by MR waiver recipients will be reviewed under the health and safety standard. This standard assures that waiver recipients receive all services necessary to assure their health and safety in the community and avoid institutionalization.

D. Appeals. Individual appeals shall be considered pursuant to 12 VAC 30-110-10 through 110-380. Provider appeals shall be considered pursuant to 12 VAC 30-10-1000 and 12 VAC 30-20-500 through 20-599.

12VAC30-120-213. Individual eligibility requirements.

A. Individuals receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR §§ 435.211, 435.217, and 435.230. The income level used for §§ 435.211, 435.217 and 435.230 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the *Social Security Act* will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and non-financial Medicaid eligibility criteria and meet the institutional level of care criteria. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR § 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR § 435.735 and §1915(c)(3) of the *Social*

Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed below:

a. For individuals to whom § 1924(d) applies and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. For the period beginning with the effective date of this emergency regulation through December 31, 2001, those individuals involved in a planned habilitation program carried out as a supported employment, prevocational, or vocational training shall be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50 percent of any additional gross earnings up to a maximum earnings allowance of $190 monthly. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than five percent of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party

including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the Plan.

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

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. For the period beginning with the effective date of this emergency regulation through December 31, 2001, those individuals involved in a planned habilitation program carried out as a supported employment, prevocational, or vocational training shall be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50 percent of any additional gross earning up to a maximum earnings allowance of $190 monthly. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than five percent of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under

state law but not covered under the State Medical Assistance Plan.

(4) The following four criteria shall apply to all mental retardation waiver services:

a. Individuals qualifying for mental retardation waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. The need for the service must arise from either (i) an individual has a diagnosed condition of mental retardation; OR (ii) a child younger than six years of age is at developmental risk of significant functional limitations in major life activities;

b. The CSP and services which are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the case manager based on a current functional assessment using a DMHMRSAS approved assessment instrument and a demonstrated need for each specific service; and

d. Individuals qualifying for mental retardation waiver services must meet the ICF/MR level of care criteria.

B. Assessment and authorization of home and community-based care services.

1. To ensure that Virginia's home and community-based care waiver programs serve only individuals who would otherwise be placed in an ICF/MR, home and community-based care services shall be considered only for individuals who are eligible for admission to an ICF/MR with a diagnosis of mental retardation, or who are under 6 years of age and at developmental risk. Home and community-based care services shall be the critical service that enables the individual to remain at home and in the community rather than being placed in an ICF/MR.

2. The individual’s need for home and community-based care services shall be determined by the CSB case manager after completion of a comprehensive assessment of the individual's needs and available support. The case manager shall complete the assessment, determine whether the individual meets the ICF/MR criteria and develop the CSP with input from the recipient, family members, service providers and any

other individuals involved in the individual's maintenance in the community. Completion of this screening process for home and community-based care services by the CSB case manager is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

3. An essential part of the case manager's assessment process shall be determining the level of care required by applying the existing DMAS ICF/MR criteria (12 VAC30-130-430 et seq.)

4. The case manager shall gather relevant medical, social, and psychological data, and identify all services received by the individual. Medical examinations shall be current, completed prior to the individual's entry to the waiver, no earlier than 12 months prior to beginning waiver services. Social assessments must have been completed no earlier than 12 months prior to beginning waiver services. Psychological evaluations or standardized developmental evaluations for children under the age of six years must reflect the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

5. The case manager shall explore alternative settings and services to provide the care needed by the individual. Based on the individual's preference, preference of parents or guardian for minors, or preference of guardian or authorized representative for adults, and the assessment of needs, a CSP shall be developed for the individual. For the case manager to make a recommendation for waiver services, community-based services must be determined to be an appropriate service alternative to delay, avoid placement in an ICF/MR, or promote exiting from either an ICF/MR placement, or inappropriate nursing facility placement.

6. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by DMHMRSAS. Any plan of care for home and community-based care services must be pre-approved by DMHMRSAS prior to Medicaid reimbursement for waiver services.

7. The case manager must submit the results of the comprehensive assessment and a recommendation to the DMHMRSAS staff for final determination of ICF/MR level of care and authorization for community-based care services. DMHMRSAS authorization must be obtained prior to service initiation and Medicaid reimbursement for waiver services. DMHMRSAS will communicate in writing to the case manager whether the recommended service plan has been approved or denied and, if approved, the amounts and type of services authorized.

8. Community-based care waiver services may be recommended by the case manager only if:

a. The individual is Medicaid eligible as determined by the local office of the Department of Social Services;

b. The individual has a diagnosis of mental retardation as defined in 37.1-1 of the Code of Virginia, or is a child under the age of six at developmental risk, who would in the absence of waiver services, require the level of care provided in an ICF/MR facility the cost of which would be reimbursed under the Plan;

c. The Consumer Service Plan and services which will be delivered are consistent with the Medicaid definition of each service; and

d. The individual requesting waiver services shall not receive such services while an inpatient of a nursing facility, an ICF/MR, or hospital.

9. All Consumer Service Plans are subject to approval by DMAS. DMAS shall be the single state agency authority responsible for the supervision of the administration of the community-based care waiver. DMAS has contracted with DMHMRSAS for recommendation of preauthorization of waiver services. DMAS will conduct utilization review of those services.

C. Waiver approval process: Accessing services.

1. Once the CSB case manager has determined an individual meets the functional criteria for mental retardation (MR) waiver services and the individual has chosen this service, the case manager and the individual or individual's family will meet within 30 calendar days to discuss the individual's needs, existing supports, and to develop a CSP which will establish and document services needed.

2. The service providers will develop Individual Service Plans (ISP) for each service and will submit a copy of these plans to the case manager. The case manager will monitor the service providers' ISPs to ensure that all providers are working toward the identified goals of the affected individuals. The case manager will review and approve the ISPs, contact DMHMRSAS for prior authorization to enroll the individual in the MR waiver and prior authorize services. DMHMRSAS shall, within 10 working days of receiving all supporting documentation either approve or deny the CSP and a waiver slot for that individual. DMHMRSAS shall only authorize the waiver slot for the individual if slots are available. Once this authorization has been received, the case manager shall submit a DMAS-122 to determine financial eligibility for participation in the Medicaid program and the individual's patient pay responsibilities. Once the case manager has received written authorization of Medicaid eligibility, the case manager shall inform the

individual so that the individual can initiate services listed in the CSP. If DMHMRSAS does not have an available slot for this individual, the individual will be held on the waiting list until such time as a slot becomes available.

3. Once the individual has been authorized by DMHMRSAS for the waiver slot, the individual or case manager shall contact service providers so that the individual may receive services within 60 days. If services are not initiated by the provider within 60 days, the case manager must submit information to DMHMRSAS and copy the individual or individual's family demonstrating why more time is needed to initiate services. DMHMRSAS has the authority to approve or suspend the request in 30-day extensions or deny the request to retain the waiver slot.

4. Case managers will be required to conduct monthly on-site visits for all consumers residing in DSS-licensed facilities.

12VAC30-120-214. General Requirements for Home and Community-based Care Participating Providers.

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

1. Immediately notify DMAS and DMHMRSAS, in writing, of any change in the information which the provider previously submitted to DMAS and DMHMRSAS.

2. Assure freedom of choice to individuals in seeking medical care 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 were performed.

3. Assure the individual's freedom to refuse medical care and treatment.

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

5. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. § § 2000d through 2000d-4a), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§§ 51.5-1 through 51.5-59 of the Code of Virginia), as amended; § 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 U.S.C. §§ 12101 through 12213), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

6. Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.

7. 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. The provider must accept as payment in full the amount established by DMAS payment methodology from the first day of the individual's eligibility for the waiver services.

8. Use program-designated billing forms for submission of charges.

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

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

10. The provider agrees to furnish information on request and in the form requested to DMAS, DMHMRSAS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement.

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

12. All providers shall hold confidential and use for authorized DMAS or DMHMRSAS purposes only all medical assistance information regarding recipients served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim

for health benefits or the data is necessary for the functioning of the DMAS.

13. Change of Ownership. When ownership of the provider agency changes, DMAS shall be notified at least 15 calendar days before the date of change.

14. All facilities covered by § 1616(e) of the *Social Security Act* in which home and community-based care services will be provided shall be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS' licensure standards, 12 VAC 35-102-10 et seq. or through DSS approved standards for adult foster care providers and licensure standards 22 VAC 40-70-10 et seq.

15. Suspected Abuse or Neglect. Pursuant to §§ 63.1-55.3 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based care recipient 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 to the local DSS adult or child protective services worker and to DMHMRSAS.

16. Adherence to provider contract and the DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider contracts and in the DMAS provider manual.

12VAC30-120-215. Participation standards for home and community-based care participating providers.

A. Requests for participation will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. For DMAS to approve contracts with home and community based care providers, the following standards shall be met:

1. For services that have licensure and certification requirements, licensure and certification requirements pursuant to 42 CFR § 441.352;

2. Disclosure of ownership pursuant to 42 CFR § § 455.104 and 455.105;

3. Administrative and financial management capacity to meet state and federal requirements; and

4. The ability to document and maintain individual case records in accordance with state and federal requirements.

C. The waiver recipient shall be informed of all available providers in the community and shall have the option of selecting the provider agency of his choice from among those agencies which can appropriately meet the individual's needs.

D. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for contract renewal with DMAS to provide home and community-based services. A provider's non-compliance with DMAS policies and procedures, as required in the provider's contract, may result in a written request from DMAS for a corrective action plan which details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies which have been cited.

E. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS shall be permitted to administratively terminate a provider from participation upon 30 days' written notification. DMAS may also cancel a contract immediately or may give notification of cancellation in the event of a breach of the contract by the provider as specified in the DMAS contract. Such action precludes further payment by DMAS for services provided to individuals subsequent to the date specified in the termination notice.

F. A provider shall have the right to appeal adverse action taken by DMAS. Adverse actions may include, but shall not be limited to, termination of the provider agreement by DMAS, and retraction of payments from the provider by DMAS for noncompliance with applicable law, regulation, policy, or procedure. All disputes regarding provider reimbursement or termination of the agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be conducted pursuant to the Virginia Administrative Process Act (§§ 9-6.14:1 through 9.6-14.25 of the Code of Virginia), the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia, and duly promulgated regulations. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

G. Section 32.1-325(C), as amended, of the Code of Virginia, mandates that "any such [Medicaid] agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, D.C., must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. Reinstatement will be contingent upon provisions of state law. In addition, termination of a provider contract will occur as may be required for federal financial participation.

H. Case manager's responsibility for the Individual Information Form (DMAS-122). It shall be the responsibility of the case management provider to notify DMHMRSAS and DSS, in writing, when any of the following circumstances occur. Furthermore, it shall be the responsibility of DMHMRSAS to update DMAS when any of the following events occur:

1. Home and community-based care services are implemented.

2. A recipient dies.

3. A recipient is discharged or terminated from services.

4. Any other circumstances (including hospitalization) which cause home and community-based care services to cease or be interrupted for more than 30 days.

5. A change in community services board providing case management services.

I. Changes or termination of care. It is the DMHMRSAS staff's responsibility to authorize changes to a recipient's CSP based on the recommendations of the case management provider. Agencies providing direct service are responsible for modifying their individual service plan, if the individual or family caregiver agrees, and submitting it to the case manager any time there is a change in the recipient's condition or circumstances which may warrant a change in the amount or type of service rendered. The case manager will review the need for a change and may recommend a change to the plan of care to the DMHMRSAS staff. DMHMRSAS will review and approve or deny the requested change to the individual's plan of care and communicate this authorization to the case manager within 10 working days of receipt of the request for change or in the case of an emergency, within 72 hours of receipt of the request for change. The DMAS staff has the final authority to approve or deny the requested change to individuals' plans of care. The individual will be notified, in writing, of the right to appeal the decisions to reduce or deny services pursuant to DMAS client appeals regulations (12 VAC 30-110-10 et seq.)

1. In a non-emergency situation, the participating provider shall give the recipient or family and case manager 10 days written notification of the intent to terminate services. The letter shall provide the reasons for such termination and the effective date of the termination. The effective date of services termination shall be at least ten days from the date of the termination notification letter.

2. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered, the case manager and DMHMRSAS must be notified prior to termination. The 10 day written notification period shall not be required. If appropriate, the local DSS

adult protective services or child protective services must be notified immediately.

3. In the case of termination of home and community-based care services by the DMHMRSAS staff, the effective date of termination shall be at least 10 days from the date of the termination notification letter. The case manager shall have the responsibility to identify those recipients who no longer meet the criteria for care or for whom home and community-based services are no longer an appropriate alternative. The DMHMRSAS staff shall have the authority to terminate home and community-based services.

4. DMAS shall have the ultimate responsibility for ensuring appropriate placement of the individual in home and community-based care services and the authority to terminate such services to the individual for the following reasons:

a. The home and community-based care service is not the critical alternative to prevent or delay institutional (ICF/MR) placement;

b. The individual no longer meets the institutional level of care criteria;

c. The individual's environment does not provide for his health, safety, and welfare;

d. An appropriate and cost-effective CSP cannot be developed; or

e. The individual loses Medicaid eligibility.

12VAC30-120-216 through 12 VAC30-120-219. Reserved.

12VAC30-120-220. General coverage and requirements for home and community-based care services.

A. Waiver service populations. Home and community-based services shall be available through a §1915(c) waiver. Coverage shall be provided under the waiver for the following individuals who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded: . This regulation shall only apply to those individuals who are receiving congregate residential services in DSS-licensed assisted living facilities that are seeking DMHMRSAS licensure pursuant to 12 VAC 30-120-230(C). This regulation shall only be in effect through September 15, 2002..

1. Individuals with mental retardation.

2. Individuals with related conditions currently residing in nursing facilities but who are being discharged to the community and determined to require specialized services.

3. Individuals under the age of six at developmental risk. At age six, these individuals must be determined to be mentally retarded to continue to receive home and community-based care services.

B. Covered services.

1. Covered services shall include: residential support, day support, supported employment, personal assistance, respite care, assistive technology, environmental modifications, nursing services, therapeutic consultation, and crisis stabilization.

2. These services shall be clinically appropriate and necessary to maintain these individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditure under the waiver must not exceed the average per capita expenditures for the level of care provided in an intermediate care facility for the mentally retarded under the State Plan that would have been made had the waiver not been granted.

C. Patient eligibility requirements.

1. Virginia shall apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy group under 42 CFR 435.211, 435.217 and 435.230. The income level used for 435.211, 435.217 and 435.230 is 300% of the current Supplemental Security Income payment standard for one person.

2. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and be Medicaid eligible in an institution. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.

3. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and §1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after deducting the following amounts in the following order from the individual's income:

a. For individuals to whom §1924(d) applies, Virginia intends to waive the requirement for comparability pursuant to §1902(a)(10)(B) to allow for the following:

(1) ~~An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a noninstitutionalized individual unless the individual is a working patient. Those individuals involved in a planned habilitation program carried out as a supported employment or prevocational or vocational training shall be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50% of any additional~~

~~gross earnings up to a maximum personal needs allowance of $575 per month (149% of the SSI payment level for a family of one with no income).~~

The basic maintenance needs for an individual, which is equal to the SSI payment for one person. For the period beginning with the effective date of this emergency regulation through December 31, 2001, those individuals involved in a planned habilitation program carried out as a supported employment, prevocational, or vocational training shall be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50 percent of any additional gross earnings up to a maximum earnings allowance of $190 monthly. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than five percent of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

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

b. For all other individuals:

(1) ~~An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a noninstitutionalized individual unless the individual is a working patient. Those individuals involved in a planned habilitation program carried out as a supported employment or prevocational or vocational training will be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50% of any additional gross earnings up to a maximum personal needs allowance of $575 per month (149% of the SSI payment level for a family of one with no income).~~

The basic maintenance needs for an individual, which is equal to the SSI payment for one person. For the period beginning with the effective date of this emergency regulation through December 31, 2001, those individuals involved in a planned habilitation program carried out as a supported employment, prevocational, or vocational training shall be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50 percent of any additional

gross earnings up to a maximum earnings allowance of $190 monthly. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than five percent of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a family at home, an additional amount for the maintenance needs of the family which shall be equal to the medically needy income standard for a family of the same size.

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

4. The following four criteria shall apply to all mental retardation waiver services:

a. Individuals qualifying for mental retardation waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. The need for the service must arise from (i) a diagnosed condition of mental retardation; (ii) a child younger than six years of age who is at developmental risk of significant functional limitations in major life activities; or (iii) a person with a related condition as defined in these regulations;

b. The Plan of Care and services which are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the case manager based on a current functional assessment using the Inventory for Client and Agency Planning (ICAP) or other DMHMRSAS approved assessment and demonstrated need for each specific service; and

d. Individuals qualifying for mental retardation waiver services must meet the ICF/MR level of care criteria.

D. Assessment and authorization of home and community-based care services.

1. The individual's need for home and community-based care services shall be determined by the CSB case manager after completion of a comprehensive assessment of the individual's needs and available support. The case manager shall complete the assessment, determine whether the individual meets the intermediate care facility for the mentally retarded (ICF/MR) criteria and develop the Consumer Service Plan (CSP) with input from the recipient, family members, service providers and any other individuals involved in the individual's maintenance in the community.

2. An essential part of the case manager's assessment process shall be determining the level of care required by applying the existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.).

3. The case manager shall gather relevant medical, social, and psychological data and identify all services received by the individual. Medical examinations shall be current, completed prior to the individual's entry to the waiver, no earlier than 12 months prior to beginning waiver services. Social assessments must have been completed within 12 months prior to beginning waiver services. Psychological evaluations or standardized developmental evaluations for children under the age of six years must reflect the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

4. The case manager shall explore alternative settings to provide the care needed by the individual. Based on the individual's preference, preference of parents or guardian for minors, or preference of guardian or authorized representative for adults, and the assessment of needs, a plan of care shall be developed for the individual. For the case manager to make a recommendation for waiver services, community-based care services must be determined to be an appropriate service alternative to delay, avoid placement in an ICF/MR, or promote exiting from either an ICF/MR placement or inappropriate nursing facility placement.

5. Community-based care waiver services may be recommended by the case manager only if:

a. The individual is Medicaid eligible as determined by the local office of the Department of Social Services,

b. The individual is either mentally retarded as defined in §37.1-1 of the Code of Virginia, is a child under the age of six at developmental risk, or is a person with a related condition who would, in the absence of waiver services, require the level of care provided in an ICF/MR facility, the cost of which would be reimbursed under the Plan,

c. The individual requesting waiver services shall not receive such services while an inpatient of a nursing facility or hospital.

6. The case manager must submit the results of the comprehensive assessment and a recommendation to the DMHMRSAS staff for final determination of ICF/MR level of care and authorization for community-based care services. DMHMRSAS authorization must be obtained prior to referral for service initiation and Medicaid reimbursement for waiver services. DMHMRSAS will communicate in writing to the case manager whether the recommended service plan has been approved or denied and, if approved, the amounts and type of services authorized.

7. All Consumer Service Plans are subject to approval by DMAS. DMAS is the single state authority responsible for the supervision of the administration of the community-based care waiver. DMAS has contracted with DMHMRSAS for recommendation of preauthorization of waiver services and utilization review of those services.

8. Case managers will be required to conduct monthly on-site visits for all consumers who reside in DSS-licensed facilities.

12VAC30-120-221 through 12VAC30-120-229. *Reserved.*

12VAC30-120-230. General conditions and requirements for all home and community-based care participating providers. This regulation shall only apply to those individuals who are receiving congregate residential services in DSS-licensed assisted living facilities that are seeking DMHMRSAS licensure pursuant to 12 VAC 30-120-230(C). This regulation shall only be in effect through September 15, 2002.

A. General requirements. Providers approved for participation shall, at a minimum, perform the following:

1. Immediately notify DMAS in writing of any change in the information which the provider previously submitted to DMAS.

2. Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the services required and participating in the Medicaid Program at the time the service was performed.

3. Assure the recipient's freedom to refuse medical care and treatment.

4. Accept referrals for services only when staff is available to initiate services.

5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin and of Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination on the basis of a handicap and both the Virginians with Disabilities Act and the Americans with Disabilities Act.

6. Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

7. Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

8. Accept Medicaid payment from the first day of the recipient's eligibility.

9. Accept as payment in full the amount established by DMAS.

10. Use program-designated billing forms for submission of charges.

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

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

b. Policies regarding retention of records shall apply even if the agency 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 of Virginia.

12. Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

13. 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.

14. Hold confidential and use for authorized DMAS or DMHMRSAS purposes only all medical assistance information regarding recipients.

15. When ownership of the provider agency changes, DMAS shall be notified within 15 calendar days of such change.

B. Requests for participation. DMAS will screen requests to determine whether the provider applicant meets the following basic requirements for participation.

C. Provider participation standards. For DMAS to approve contracts with home and community-based care providers the following standards shall be met:

1. The provider must have the ability to serve individuals in need of waiver services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement.

2. The provider must have the administrative and financial management capacity to meet state and federal requirements.

3. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements.

4. The provider of residential and day support services must be licensed by DMHMRSAS as a provider of residential services, supportive residential services, or day support services. These licensing requirements address standards for personnel, residential and day program environments, and program and service content. They must also have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support

methods for persons with mental retardation and functional limitations. ~~Residential support services may also be provided in programs licensed by DSS (adult care residences) or in adult foster care homes approved by local DSS offices pursuant to state DSS regulations. In addition to licensing requirements, persons providing residential support services are required to pass an objective, standardized test of skills, knowledge and abilities developed by DMHMRSAS and administered according to DMHMRSAS policies.~~

Residential support services may also be provided in programs licensed by DSS (assisted living facilities) or in adult foster care homes approved by local DSS offices pursuant to state DSS regulations, for MR waiver recipients who reside in those facilities as of September 15, 2001. Services may continue to be provided for those recipients under the DSS license until September 15, 2002. The assisted living facilities must file an application for licensure by DMHMRSAS as a residential services provider by September 15, 2001. DSS-licensed providers who are providing residential services in assisted living facilities that do not file an application for licensure with DMHMRSAS by September 15, 2001, will be terminated as a provider of MR waiver residential support services. Assisted living facilities that are seeking licensure through DMHMRSAS to provide residential services will need to be licensed by September 15, 2002, in order to continue providing residential services to individuals in the MR waiver. In addition to licensing requirements, persons providing residential support services are required to pass an objective, standardized test of skills, knowledge, and abilities developed by DMHMRSAS and administered according to DMHMRSAS policies.

5. Supported employment or prevocational training services shall be provided by agencies that are either licensed by DMHMRSAS as a day support service or are vendors of extended employment services, long-term employment support services or supportive employment services for DRS.

6. Services provided by members of professional disciplines shall meet all applicable state licensure or certification requirements. Persons providing behavior consultation shall be certified by DMHMRSAS based on the individual's work experience, education and demonstrated knowledge, skills, and abilities. Persons providing rehabilitation engineering shall be contracted with DRS.

7. All facilities covered by §1616(e) of the Social Security Act in which home and community-based care services will be provided shall be in compliance with applicable standards that meet

the requirements of 45 CFR Part 1397 for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS's licensure standards, 12VAC35-102-10 et seq. or through DSS licensure standards 22VAC40-70-10 et seq.

8. Personal assistance services shall be provided by a DMAS certified personal care provider whose staff has passed the DMHMRSAS objective standardized test for residential support services, or by a DMHMRSAS licensed residential support provider.

9. Respite care services shall be provided by a DMAS certified personal care provider; a DMHMRSAS licensed supportive residential provider, respite care services provider (center based or out-of-home) or in-home respite care provider; an approved DSS foster care home for children or adult foster home provider; or be registered with the CSB as an individual provider of respite care as defined in 12VAC35-102-10.

10. Nursing services shall be provided by a DMAS certified private duty nursing or home health provider or by a licensed registered nurse or licensed practical nurse contracted or employed by the CSB.

11. Environmental modifications shall be provided in accordance with all applicable state or local building codes by contractors of the CSB or DRS who shall be reimbursed for the amount charged by said contractors.

12. Assistive technology shall be provided by agencies under contract with DMAS as a durable medical equipment and supply provider. Any equipment/supplies/technology not available through a durable medical equipment provider may be purchased and billed to DMAS for Medicaid reimbursement as documented in the Plan of Care, approved by the case manager, and monitored by DMHMRSAS.

13. Crisis stabilization services shall be provided by agencies licensed by DMHMRSAS as a provider of outpatient services or residential or supportive residential services or day support services. To provide the crisis supervision component, agencies must be licensed by DMHMRSAS as providers of residential services or supportive residential services. The provider agency must employ or utilize qualified mental retardation professionals, licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities to individuals with mental retardation who are experiencing serious psychiatric or behavioral problems. The qualified mental retardation professional shall have (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

D. Adherence to provider contract and DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider contracts and in the DMAS provider service manual.

E. Recipient choice of provider agencies. The waiver recipient shall be informed of all available providers in the community and shall have the option of selecting the provider agency of his choice from among those agencies which can appropriately meet the individual's needs.

F. Termination of provider participation. DMAS may administratively terminate a provider from participation upon 60 days' written notification. DMAS may also cancel a contract immediately or may give such notification in the event of a breach of the contract by the provider as specified in the DMAS contract. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

G. Reconsideration of adverse actions. Adverse actions may include, but are not limited to, disallowed payment of claims for services rendered which are not in accordance with DMAS policies and procedures, contract limitation or termination. The following procedures shall be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

1. The reconsideration process shall consist of three phases:

a. A written response and reconsideration of the preliminary findings.

b. The informal conference.

c. The formal evidentiary hearing.

2. The provider shall have 30 days to submit information for written reconsideration, 15 days from the date of the notice to request the informal conference, and 15 days from the date of the notice to request the formal evidentiary hearing.

3. An appeal of adverse actions shall be heard in accordance with the Administrative Process Act (§9-6.14:1 et seq. of the Code of Virginia) and the State Plan for Medical Assistance provided for in §32.1-325 of the Code of Virginia. Court review of the final agency determination shall be made in accordance with the Administrative Process Act.

H. Responsibility for sharing recipient information. It shall be the responsibility of the case management provider to notify DMHMRSAS and DSS, in writing, when any of the following circumstances occur. Furthermore, it shall be the responsibility of DMHMRSAS to update DMAS when any of the following events occur:

1. Home and community-based care services are implemented.

2. A recipient dies.

3. A recipient is discharged or terminated from services.

4. Any other circumstances (including hospitalization) which cause home and community-based care services to cease or be interrupted for more than 30 days.

I. Changes or termination of care. It is the DMHMRSAS staff's responsibility to authorize any changes to a recipient's CSP based on the recommendation of the case management provider.

1. Agencies providing direct service are responsible for modifying their individual service plan and submitting it to the case manager any time there is a change in the recipient's condition or circumstances which may warrant a change in the amount or type of service rendered.

2. The case manager will review the need for a change and may recommend a change to the plan of care to the DMHMRSAS staff.

3. The DMHMRSAS staff will approve or deny the requested change to the recipient's plan of care and communicate this authorization to the case manager within 10 days of receipt of the request for change or in the case of an emergency, within 72 hours of receipt of the request for change.

4. The case manager will communicate in writing the authorized change in the recipient's plan of care to the individual service provider and the recipient, in writing, providing the recipient with the right to appeal the decision pursuant to DMAS Client Appeals Regulations (12VAC30-110-10 et seq.).

5. Nonemergency termination of home and community-based care services by the individual service provider. The individual service provider shall give the recipient and/or family and case manager 10 days written notification of the intent to terminate services. The letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least 10 days from the date of the termination notification letter.

6. Emergency termination of home and community-based care services by the individual services provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered, the case manager and DMHMRSAS staff must be notified prior to termination. The 10-day written notification to the individual shall not be required.

7. Termination of home and community-based care services for a recipient by the DMHMRSAS staff. The effective date of termination shall be at least 10 days from the date of the termination notification letter. The case manager has the responsibility to identify those recipients who no longer meet the criteria for care or for whom home and community-based services are no longer an appropriate alternative. The DMHMRSAS staff has the authority to terminate home and community-based care services.

J. Suspected abuse or neglect. Pursuant to §63.1-55.3 of the Code of Virginia, if a participating provider agency knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse/neglect/exploitation shall report this to the local DSS.

K. DMAS monitoring. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for contract renewal with DMAS to provide home and community-based services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's contract, may

result in a written request from DMAS for a corrective action plan which details the steps the provider will take and the length of time required to achieve full compliance with deficiencies which have been cited.

12VAC30-120-231 through 12VAC30-120-239. *Reserved.*

12VAC30-120-240. Covered services and limitations. This regulation shall only apply to those individuals who are receiving congregate residential services in DSS-licensed assisted living facilities that are seeking DMHMRSAS licensure pursuant to 12 VAC 30-120-230(C). This regulation shall only be in effect through September 15, 2002.

A. Residential support services shall be provided in the recipient's home (including the home of a relative or other person, a foster home or an adult family care home), in a licensed adult care residence or licensed group home. The service shall be designed to enable individuals qualifying for the mental retardation waiver to be maintained in living arrangements in the community and shall include: (i) training in or reinforcement of functional skills and appropriate behavior related to a recipient's health and safety, personal care, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring health, nutrition and physical condition; and (iii) assistance with personal care activities of daily living and use of community resources. Service providers shall be reimbursed only for the amount and type of residential support services included in the individual's approved plan of care. Residential support services shall not be authorized in the plan of care unless the individual requires these services and these services exceed the care included in the individual's room and board arrangement for individuals residing in an adult care residence or group home, or, for other individuals, if these services exceed services provided by the family or other caregiver. In order to qualify for this service in an adult care residence or a group home, the individual shall have a demonstrated need for continuous training, assistance, and supervision for up to 24 hours in a residential setting provided by paid staff. For other individuals, services will not routinely be provided across a continuous 24-hour period.

1. All individuals must meet the following criteria in order for Medicaid to reimburse for mental retardation residential support services. The individual must meet the eligibility requirements for this waiver service as herein defined. The individual shall have a demonstrated need for supports to be provided by paid staff by the residential support provider.

2. An individual's case manager shall not be the direct service staff person or the immediate supervisor of a staff person who provides supported living services to the individual.

3. This service must be provided on an individualized basis according to the plan of care and service setting requirements.

4. This service may not be provided to any individual who receives personal assistance services under the mental retardation community waiver or other residential program that provides a comparable level of care.

5. Room and board and general supervision shall not be components of this service.

6. This service shall not be used solely to provide routine or emergency respite care for parent or other care givers with whom the individual lives.

B. Day support services include a variety of training, support, and supervision offered in a setting which allows peer interactions and community integration. If prevocational services are offered, the plan of care must contain documentation regarding whether prevocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or in special education services through §602(16) and (17) of the Individuals with Disabilities Education Act. When services are provided through these sources, the plan of care shall not authorize them as a waiver funded expenditure. Compensation for prevocational services can only be made when the individual's productivity is less than 50% of the minimum wage. Service providers are reimbursed only for the amount and type of day support services included in the individual's approved plan of care based on the setting, intensity and duration of the service to be delivered. In order to qualify for prevocational service, the individual shall have a demonstrated need for support in skills which are aimed towards preparation of paid employment which may be offered in a variety of community settings. For day support services, individuals shall have demonstrated the need for functional training, assistance and specialized supervision offered in settings, other than the individual's own residence, which allow an opportunity for being productive and contributing members of their communities.

C. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized supervision to enable a consumer to maintain paid employment. Each plan of care must contain documentation regarding whether supported employment services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or in special education services through §602(16) and (17) of the Individuals with Disabilities Education Act. When services are provided through these sources, the plan of care shall not authorize them as a waiver funded expenditure. Service providers are reimbursed only for the amount and type of habilitation services included in the individual's approved plan of care based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of supported employment, not for the amount of time the individual is in the supported employment environment. In order to qualify for these services, the individual shall have a demonstrated need for training, specialized supervision, or assistance in paid employment and for whom competitive employment at or above the minimum wage is unlikely without this support and who, because of the disability, needs ongoing support, including supervision, training and transportation to perform in a work setting.

D. Therapeutic consultation is available under the waiver for Virginia licensed or certified practitioners in psychology, social work, occupational therapy, physical therapy, therapeutic recreation, rehabilitation engineering, and speech therapy. Behavior consultation performed by persons certified by DMHMRSAS based on the individual's work experience, education and demonstrated knowledge, skills, and abilities may also be a covered waiver service. These services may be provided, based on the individual plan of care, for those individuals for whom

specialized consultation is clinically necessary to enable their utilization of waiver services. Therapeutic consultation services, other than behavior consultation, may be provided in residential or day support settings or in office settings in conjunction with another waiver service. Behavior consultation may be offered in the absence of any other waiver service when the consultation provided to informal caregivers is determined to be necessary to prevent institutionalization. Service providers are reimbursed according to the amount and type of service authorized in the plan of care based on an hourly fee for service. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need indicates that the Plan of Care could not be implemented effectively and efficiently without such consultation from this service.

E. Environmental modifications shall be available to individuals who are receiving at least one other waiver service. It is provided primarily in the individual's home or other community residence in accordance with all applicable state or local building codes. A maximum limit of $5,000 may be reimbursed in a year. In order to qualify for these services, the individual shall have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in a consumer's home, vehicle, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance.

F. Personal assistance is available only for individuals who do not receive residential services or live in adult care residences and for whom training and skills development are not objectives or are provided through another program or service. In order to qualify for these services, the individual shall have demonstrated a need for personal assistance in activities of daily living, medication or other medical needs or monitoring health status or physical condition.

G. Respite care services are limited to a maximum of 30 days or 720 hours per year. In order to qualify for these services, the individual shall have a demonstrated need for substitute care/temporary care which is normally provided by a primary care giver to provide relief for the family or surrogate family/care giver. This care shall not be provided to relieve group home or adult care residence staff where residential care is provided in paid shifts.

H. Nursing services are for individuals with serious medical conditions and complex health care needs which require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled nursing is provided in the individual's home or other community setting on a regularly scheduled or intermittent need basis. The plan of care must indicate that the service is necessary to prevent institutionalization and is not available under the State Plan for Medical Assistance. In order to qualify for these services, the individual shall have demonstrated complex health care needs which require specific skilled nursing services which are ordered by a physician and which cannot be otherwise accessed under the Title XIX State Plan.

I. Assistive technology is available to individuals who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. A maximum limit of $5,000 may be reimbursed in a year. In order to qualify for these services, the individual shall have a demonstrated need for equipment or modification for remedial or medical benefit primarily in a consumer's home, vehicle, 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.

J. Crisis stabilization services shall provide, as appropriate, neuropsychological, psychiatric, psychological and other assessments and stabilization, functional assessments, medication management and behavior assessment, behavior support, intensive care coordination with other agencies and providers to assist planning and delivery of services and supports to maintain community placement of the recipient; training of family members and other care givers and service providers in positive behavioral supports to maintain the recipient in the community; and temporary crisis supervision to ensure the safety of the recipient and others. The unit for each component of the service shall equal one hour. This service may be authorized for provision of a maximum period of 15 days and during no more than 60 days in a calendar year. The actual service units per episode shall be based on the documented clinical needs of the individuals being served.

1. These services shall be available to individuals who meet at least one of the following criteria:

a. Individual is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;

b. Individual is experiencing extreme increase in emotional distress;

c. Individual needs continuous intervention to maintain stability; or

d. Individual is causing harm to himself or others.

2. This service shall be designed to stabilize the recipient and strengthen the current semi-independent living situation, or situation with family or other primary care givers so the recipient can be maintained during and beyond the crisis period. These services may be provided directly in, but not limited to, the following settings:

a. The home of an individual who lives with family, friends, or other primary care giver or givers;

b. The home of an individual who lives independently/semi-independently to augment any current services and supports;

c. A community-based residential program to augment current services and supports;

d. A day program or setting to augment current services and supports; or

e. A respite care setting to augment current services and supports.

3. These services may be initiated following a documented face-to-face assessment by a qualified mental retardation professional. If appropriate, the assessment shall be conducted jointly with a licensed mental health professional or other appropriate professional or professionals. Crisis supervision, if provided as part of this service, shall be separately billed in hourly service units. The need for this service or an extension of the authorization for this service must be clearly documented following a documented face-to-face reassessment conducted by a qualified mental retardation professional. If appropriate, the reassessment will be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.

4. An Individualized Service Plan (ISP) must be developed or revised within 72 hours of assessment or reassessment. Crisis supervision may be provided as a component of this service only if clinical/behavioral intervention allowable under this service also is provided during authorized period. Crisis supervision must be provided one-to-one and face-to-face with the recipient.

5. This service shall not be used for continuous long-term care beyond the service limits. Room and board and general supervision shall not be components of this service and shall not be included in reimbursement.

Subpart 2.
Covered services and limitations and related provider requirements.

12VAC30-120-241. **Assistive technology.**

A. Service description. Assistive technology shall mean the specialized medical equipment and supplies including those devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live or which are necessary to their proper functioning.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modification for remedial or medical benefit primarily in the individual's home, vehicle, 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.

C. Service units and service limitations. Assistive technology (AT) is available to individuals who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. A maximum limit of $5,000 may be reimbursed per calendar year. Costs for assistive technology cannot be carried over from year to year and must be preauthorized each CSP year. AT shall not be approved for purposes of convenience of the caretaker or restraint of the individual. An independent consultation must be obtained for each AT request prior to approval by DMHMRSAS. All AT must be prior authorized by DMHMRSAS. Any equipment/supplies/technology not available through a durable medical equipment provider may be purchased and billed to DMAS for Medicaid reimbursement as documented in the Plan of Care, approved by the case manager, and authorized by DMHMRSAS.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, assistive technology shall be provided by agencies under contract with the DMAS as providers.

12VAC30-120-242. Companion care (agency-directed model of care).

A. Service description. Companion care is a covered service when its purpose is to provide non-medical care, socialization, or supervision to those individuals who require the physical presence of an aide to ensure their safety during times when no other supportive individuals are available. Companions may assist or supervise the individual with such tasks as meal preparation, community access, laundry and shopping, but do not perform these activities as a discrete services. Companions may also perform light housekeeping tasks.

B. Criteria.

1. The inclusion of companion care in the CSP is appropriate only when the individual cannot be left alone for extended periods of time or needs assistance or supervision to perform daily tasks. This includes individuals who cannot use a phone to call for help due to a physical or neurological disability;

2. Individuals who have a current, uncontrolled medical condition which would make them unable to call for help during a rapid deterioration of their health status can be approved for companion care if there is documentation that these individuals have had recurring episodes or health crises prior to the authorization of companion care;

3. There must be a clear and present danger to the individual as a result of being left unsupervised; OR

4. Companion aide services must be necessary to ensure the individual's safety if the individual cannot be left unsupervised due to health and safety concerns. Companion care can be authorized when no one else is in the home who is competent to call for help in an emergency. Companion care shall not be covered if required only because the individual does not have a telephone in his homes, because the individual does not speak English or for the individual whose only need for companion care is for assistance exiting the home in the event of an emergency.

C. Service units and service limitations.

1. The amount of companion care time included in the CSP may not exceed eight hours per 24-hour day.

2. A companion care aide shall not be permitted to supervise individuals who require ventilators, continuous tube feedings, or those who require suctioning of their airways.

3. Companion care may be authorized for family members to sleep either during the day or during the night when the individual cannot be left alone at any time, due to the individual's severe agitation and physically wandering behavior.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, providers must meet the following qualifications:

1. Companion aide qualifications. Agencies must employ individuals to provide companion care who meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic reading, writing, and math skills;

c. Be capable of following a plan of care with minimal supervision;

d. Submit to a criminal history record check. The companion aide will not be compensated for services provided to the individual if the records check verifies the companion aide has been convicted of crimes described in §37.1-183.3 of the Code of Virginia;

e. Possess a valid Social Security number; and

f. Be capable of aiding in the activities of daily living or instrumental activities of daily living.

2. Companion care providers may not be the parents of minor children, the individuals' spouses, or the legally responsible relatives of the individuals. Payment may be made for services furnished by other family members of the individual being served when there is objective written documentation as to why there are no other providers available to provide the care.

3. Companions will be employees of agencies that will contract with DMAS to provide companion services. Agencies will be required to have a companion care supervisor to monitor companion care services. The supervisor must have a bachelor's degree in a human services field and at least one year of experience working in the mental retardation field, or be a certified Home Health Aide, or an LPN or an RN. Home

health aides, LPNs, and RNs must have a current license or certification to practice nursing in the Commonwealth within his or her profession.

4. The provider agency must conduct an initial home visit prior to initiating companion care services to document the efficacy and appropriateness of services and to establish a service plan for the individual. The agency must provide follow-up home visits to monitor the provision of services quarterly or as often as needed. The individual must be reassessed for services annually.

12VAC30-120-243. Consumer-directed services: personal assistance, companion care, and respite care.

A. Service definition.

1. Consumer-directed personal assistance services may include assistance with eating, bathing, dressing, personal hygiene, activities of daily living, access to the community; medication or other medical needs and monitoring health status and physical condition. When specified, such supportive services may include assistance with instrumental activities of daily living (IADLs). Personal assistance does not include either practical or professional nursing services or those practices regulated in Chapters 30 and 34 of Subtitle III of Title 54.1 of the Code of Virginia, as appropriate.

An additional component to consumer-directed personal assistance services shall be work-related personal assistance services. This service will extend the ability of the personal assistant to provide assistance to the individual in the workplace. These services may include filing, retrieving work materials that are out of reach; providing travel assistance for an individual with a mobility impairment; helping an individual with organizational skills; reading handwritten mail to an individual with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment.

2. Consumer-directed respite care means services specifically designed to provide a temporary but periodic or routine relief to the primary unpaid caregiver of an individual. Respite care services includes assistance with personal hygiene, nutritional support, and environmental support authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

3. Consumer-directed companion care is a covered service when its purpose is to provide non-medical care, socialization, and supervision to those individuals who require the physical presence of an aide to ensure their safety during times when no other supportive individuals are available.

4. DMAS shall either provide for fiscal agent services or contract for the services of a fiscal agent for consumer-directed personal assistance services, companion care, and consumer-directed respite services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Criteria.

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

2. Consumer-directed respite care may only be offered to individuals who have a primary unpaid caregiver living in the home. The primary caregiver may require temporary relief to avoid institutionalization of the individual. This service is designed to focus on the need of the caregiver for temporary or periodic relief.

3. The inclusion of consumer-directed companion care in the CSP shall be appropriate only when the individual cannot be left alone for extended periods of time or needs assistance or supervision to perform daily tasks.

4. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal assistants or companions and supervise the assistant's or companion's performance. If an individual is unable to direct his own care, a family caregiver may serve as the employer on behalf of the individual. No more than two individuals are permitted to share the authorized work hours by the assistant or aide who live in the same home.

5. Responsibilities as employer. The individual, or if the individual is unable then a family caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing personal assistants and companions. Specific employer duties include checking references of personal assistants/companions, determining that personal assistants/companions meet basic qualifications, training personal assistants/companions, supervising the personal assistant's/ companion's performance, and submitting timesheets to the CD Services Facilitator and fiscal agent on a consistent and timely basis. The individual or family caregiver must have an emergency back-up plan in case the personal assistant/companion does not show up for work as expected or terminates employment without prior notice.

C. Service units and service limitations.

1. Consumer-directed respite care services are limited to a maximum of 720 hours per calendar year. Individuals who receive consumer-directed respite and agency-directed respite services cannot receive more than 720 hours combined.

2. The amount of consumer-directed companion care time included in the CSP must be no more than is necessary to prevent the physical deterioration or injury to the individual, to ensure the individual's health and safety, or for individuals who have a current, uncontrolled medical condition which would make them unable to call for help during a rapid deterioration of their health status.

3. For consumer-directed personal assistance and consumer-directed respite care services, individuals or family caregivers will hire their own personal assistants and manage and supervise the assistants' performance.

a. The assistant/companion must meet the following requirements:

(1) Be 18 years of age or older;

(2) Have the required skills to perform consumer-directed services as specified in the individual's supporting documentation;

(3) Possess basic math, reading, and writing skills;

(4) Possess a valid Social Security number;

(5) Submit to a criminal records check and, if the individual is a minor, the child protective services registry review. The personal assistant/companion will not be compensated for services provided to the individual if either of these records check verifies the personal assistant/companion has been convicted of crimes described in the Code of Virginia § 37.1-183.3 or if the personal assistant/companion has a complaint confirmed by the DSS child protective services registry.

(6) Be willing to attend training at the individual's or family caregiver's request;

(7) Understand and agree to comply with the DMAS MR waiver requirements;

(8) Receive annual tuberculosis (TB) screening, cardiopulmonary resuscitation (CPR) training and an annual flu shot; and

(9) Be willing to register in a personal assistant registry which will be maintained by the consumer-directed services facilitator chosen by the individual or individual's family caregiver.

4. Restrictions. Assistants may not be the parents of minor children, the individuals' spouses, or legally responsible relatives of the individuals. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care.

5. Retention, hiring, and substitution of assistants. Upon the individual's request, the CD services facilitation provider shall provide the individual or family caregiver with a list of persons on the personal assistant registry who can provide temporary assistance until the assistant returns or the individual is able to select and hire a new personal assistant. If an individual is consistently unable to hire and retain the employment of an assistant to provide consumer-directed personal assistance, companion, respite services, CD services facilitation provider must contact the case manager and DMMHMRSAS to transfer the individual, at the individual's or family caregiver's choice, to a provider which provides Medicaid-funded agency-directed personal assistance, companion care, or respite care services. The CD services facilitation provider will make arrangements with the case manager to have the individual transferred.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, the CD services facilitation provider must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitation provider and maintain provider status, the CD services facilitation provider must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the needed plans of care development and monitoring, reassessments, service coordination, and support activities as required. It is preferred that the employee of the CD services facilitation provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the individual have two years of satisfactory experience in the human services field working with persons with mental retardation. The individual must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented

on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

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

(2) Physical assistance that may be required by people with mental retardation, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by people with mental retardation which reduces the need for human help and improves safety;

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

(5) MR waiver requirements, as well as the administrative duties for which the individual will be responsible;

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

(7) Interviewing techniques;

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

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

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to persons with mental retardation; and

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

c. Abilities to:

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

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

(3) Be persistent and remain objective;

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

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

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

2. If the CD services facilitation staff employed by the CD services facilitation provider is not a RN, the CD services facilitation provider must have RN consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The RN consultant is to be available as needed to consult with individuals and CD services facilitation providers on issues related to the health needs of the individual.

3. Initiation of services and service monitoring.

a. For consumer-directed personal assistance services, the CD services facilitation provider must make an initial comprehensive home visit to assist in the development of the ISP with the individual or family caregiver and provide management training. The CD services facilitation provider will continue to monitor the ISP quarterly or on an as-needed basis. The initial comprehensive visit is done only once upon the individual's initial entry into the service. If a waiver individual changes CD-services-facilitation provider agencies, the new CD services

facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

b. For consumer-directed respite and companion services, the CD services facilitation provider must make an initial comprehensive home visit to assist with the development of the ISP with the individual or family caregiver and will provide management training. The initial comprehensive visit is done only once upon the individual's initial entry into the service. After the initial visit, the CD services facilitator will review the utilization of consumer-directed companion services quarterly or for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first. If an individual changes CD services facilitation agencies, the new CD-services-facilitation provider must bill for a reassessment in lieu of a comprehensive visit. A face-to-face meeting with the individual must be conducted at least every six months to ensure appropriateness of services.

4. During visits to the individual's home, the CD services facilitation provider must observe, evaluate, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical, and social needs. The CD services facilitation provider's summary must include, but not necessarily be limited to:

a. Whether the service is adequate to meet the individual's needs;

b. Any special tasks performed by the assistant/companion and the assistant's/companion's qualifications to perform these tasks;

c. Individual's satisfaction with the service;

d. Hospitalization or change in medical condition, functioning, or cognitive status;

e. Other services received and their amount; and

f. The presence or absence of the assistant/companion in the home during the CD services facilitator's visit.

5. The CD services facilitation provider must be available to the recipient by telephone.

6. The CD services facilitation provider must submit a criminal record check pertaining to the personal assistant/companion on behalf of the recipient and report findings of the criminal record check to the recipient or the family caregiver and the program's fiscal agent. Personal

assistants/companions will not be reimbursed for services provided to the individual effective with the date that the criminal record check confirms a personal assistant has been found to have been convicted of a crime as described in the § 37.1-183.3 of the Code of Virginia or if the personal assistant/companion has a confirmed record on the DSS Child Protective Services Registry. If the individual is a minor, the personal assistant/companion must also be screened through the DSS child protective services registry. The criminal record check and DSS Child Protective Services registry finding must be submitted prior to beginning CD services.

7. The CD services facilitation provider shall verify bi-weekly timesheets signed by the individual or the family caregiver and the personal assistant/companion to ensure that the number of CSP approved hours are not exceeded. If discrepancies are identified, the CD services facilitation provider must contact the individual to resolve discrepancies and must notify the fiscal agent. If an individual is consistently being identified as having discrepancies in his timesheets, the CD services facilitation provider must contact the case manager to resolve the situation. The CD services facilitation provider cannot verify timesheets for personal assistants/companions who have been convicted of crimes described in the § 37.1-183.3 of the Code of Virginia or who have a confirmed case with the DSS Child Protective Services Registry and must notify the fiscal agent.

8. Personal assistant registry. The CD services facilitation provider must maintain a personal assistant registry.

9. Required documentation in individuals' records. The CD services facilitation provider must maintain all records of each individual. At a minimum these records must contain:

   a. All copies of the ISP and all DMAS-122 forms.

   b. CD services facilitation provider's notes recorded and dated documenting any contacts with the individual and visits to the individual's home.

   c. All correspondence to the individual, the case manager, and to DMHMRSAS.

   d. Reassessments made during the provision of services.

   e. Records of contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the individual.

f. All training provided to the personal assistant/companion or assistants/companions on behalf of the individual or family caregiver.

g. All management training provided to the individuals or family caregivers, including the individual's or family caregiver's responsibility for the accuracy of the assistant's/companion's timesheets.

h. All documents signed by the individual or the individual's family caregivers that acknowledge the responsibilities of the services.

12VAC30-120-244. Crisis stabilization services.

A. Service description. Crisis stabilization services shall provide, as appropriate, neuropsychological, psychiatric, psychological and other assessments and stabilization, functional assessments, medication management and behavior assessment, behavior support, intensive care coordination with other agencies and providers. This service shall be designed to stabilize the individual and strengthen the current semi-independent living situation, or situation with family or other primary caregivers, so the individual can be maintained during and beyond the crisis period. These services shall be provided to:

1. Assist planning and delivery of services and supports to maintain community placement of the individual;

2. Train family members and other care givers and service providers in positive behavioral supports to maintain the recipient in the community; and

3. Provide temporary crisis supervision to ensure the safety of the individual and others.

B. Criteria.

1. In order to receive crisis stabilization services, the individual must meet at least one of the following criteria:

a. The individual is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;

b. The individual is experiencing extreme increase in emotional distress;

c. The individual needs continuous intervention to maintain stability; or

d. The individual is causing harm to self or others.

2. The individual must be at risk of at least one of the following:

a. Psychiatric hospitalization;

b. Emergency ICF/MR placement;

c. Disruption of community status (living arrangement, day placement, or school); or

d. Causing harm to self or others.

C. Service units and service limitations. Crisis stabilization services must be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional.

1. The unit for each component of the service is one hour. This service may be authorized in 15-day increments but no more than 60 days in a calendar year may be used. The actual service units per episode shall be based on the documented clinical needs of the individuals being served. Extension of services, beyond the 15-day limit per authorization, must be authorized following a documented face-to-face reassessment conducted by a qualified professional.

2. Crisis stabilization services may be provided directly in the following settings *(examples below are not exclusive):*

a. The home of an individual who lives with family, friends, or other primary caregiver or caregivers;

b. The home of an individual who lives independently or semi-independently to augment any current services and support;

c. A community-based residential program to augment current services and supports;

d. A day program or setting to augment current services and supports; or

e. A respite care setting to augment current services and supports.

3. Crisis supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision, if provided as a part of this service, shall be separately billed in hourly service units. The need for this service or an extension of the authorization for this

service must be clearly documented following a documented face-to-face reassessment conducted by a qualified mental retardation professional.

4. Crisis supervision must be provided face-to-face with the individual. Crisis stabilization services shall not be used for continuous long-term care. Room and board and general supervision are not components of this service.

5. If appropriate, the assessment shall be conducted jointly with a licensed mental health professional or other appropriate professional or professionals. If appropriate, the reassessment will be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.

D. Provider requirements. In addition to the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, the following specific provider qualifications apply:

1. Crisis stabilization services shall be provided by agencies licensed by DMHMRSAS as a provider of outpatient services or residential or supportive residential services, or day support services. To provide the crisis supervision component, agencies must be licensed by DMHMRSAS as providers of residential services or supportive residential services or day support services. The provider agency must employ or utilize qualified mental retardation professionals, licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities to individuals with mental retardation who are experiencing serious psychiatric or behavioral problems. The qualified mental retardation professional shall have: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

2. An ISP must be developed or revised and submitted to the case manager for submission to DMHMRSAS within 72 hours of assessment or reassessment.

3. Documentation indicating the dates and times of crisis stabilization services and amount and type of service provided must be recorded in the individual's record.

4. Documentation of qualifications of providers must be maintained for review by DMHMRSAS and DMAS staff.

12VAC30-120-245. Day support services.

A. Service description. Day support services shall include a variety of training, support, and specialized supervision offered in a non-residential setting which allows peer interactions and community and social integration.

B. Criteria. For day support services, individuals must demonstrate the need for functional training, assistance, and specialized supervision offered in settings other than the individual's own residence which allow an opportunity for being productive and contributing members of communities.

1. A functional assessment may be conducted by the provider to evaluate each individual in the day support environment and community settings.

2. Levels of day support. The amount and type of day support included in the individual's consumer service plan is determined according to the services required for that individual. There are two types of day support: center-based, which is provided partly or entirely in a segregated setting, or non-center-based, which is provided entirely in community settings. Both types of day support may be provided at either intensive or regular levels. To be authorized at the intensive level, the individual must have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish his service goals; or the individual requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program or objectives is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

C. Service units and service limitations. Day support cannot be regularly or temporarily (e.g., due to inclement weather or individual illness) provided in a individual's home or other residential setting without written prior approval from DMHMHRSAS. Non-center-based day support services must be separate and distinguishable from either residential support services or personal assistance services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The supporting documentation must provide an estimate of the amount of day support required by the individual. Service providers are reimbursed only for the amount and type of day support services included in the individual's approved CSP based on the setting, intensity, and duration of the service to be delivered.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, day support providers need to meet additional requirements.

1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services. These licensing requirements address standards for personnel, day program environments, and program and service content. Day support staff must also have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations.

2. An ISP which contains, at a minimum, the following elements:

   a. The individual's strengths, desired outcomes, required or desired supports and training needs;

   b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

   c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

   d. All individuals or organizations that will provide the services specified in the statement of services;

   e. A timetable for the accomplishment of the individual's goals and objectives;

   f. The estimated duration of the individual's needs for services; and

   g. The individual or individuals responsible for the overall coordination and integration of the services specified in the ISP.

3. Documentation must confirm the individual's attendance and amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives.

   a. The ISP goals, objectives, and activities must be reviewed by the provider annually, or more often as needed with the individual receiving the services, and this review submitted to the case manager. In addition, the ISP goals, objectives, and activities must be reviewed by the provider quarterly, modified as appropriate and submitted to the case manager.

   b. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and the number of hours and units provided.

c. Documentation must indicate whether the services were center-based or non-center-based.

d. Documentation that billing for non-program related transportation does not exceed 25% of the total time billed that day.

e. If intensive day support services are requested, documentation must be present in the individual's record to indicate the specific supports and the reasons they are needed. For ongoing intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.

f. Copy of the most recently completed DMAS 122 form.

4. During the 60-day assessment period, documentation must confirm attendance and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives. Assessment results should be available in at least a daily note or weekly summary.

12VAC30-120-246. Environmental modifications.

A. Service description. Environmental modifications shall be defined as those physical adaptations to the home, vehicle, or work site required by the individual's CSP, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home and work site and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. All services shall be provided in the individual's home or other community residence in accordance with applicable state or local building codes. Modifications can be made to an automotive vehicle if it is the primary vehicle being used by the individual.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in an individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program.

C. Service units and service limitations. Environmental modifications shall be available to individuals who are receiving at least one other waiver service along with targeted case management. A maximum limit of $5,000 may be reimbursed per CSP year. Costs for environmental modifications shall not be carried over

from CSP year to year and must be prior authorized by DMHMRSAS for each CSP year. Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repairs, central air conditioning, etc. Adaptations which add to the total square footage of the home shall be excluded from this benefit.

D. Provider requirements. In addition to meeting the general conditions and requirements for HCBC participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215. Environmental modifications must be provided in accordance with all applicable state or local building codes by contractors of the CSB or providers who contract with DMAS who shall be reimbursed for the amount charged by said contractors. The following are provider documentation requirements:

1. An ISP that documents the need for the service, the process to obtain the service, and the time frame during which the services are to be provided. The ISP must include documentation of the reason that a Rehabilitation Engineer or Specialist is needed, if one is to be involved;

2. Documentation of the time frame involved to update the modification and the amount of services and supplies

3. Any other relevant information regarding the modification;

4. Documentation of notification by the consumer or consumer's representative of satisfactory completion of the service; and

5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed.

12VAC30-120-247. Personal assistance services.

A. Service description. Personal assistance shall provide care to individuals with activities of daily living, medication or other medical needs or the monitoring of health status or physical condition. It may be provided in residential and non-residential settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

B. Criteria. In order to qualify for these services, the individual must demonstrate a need for activities of daily living, medication or other medical needs or monitoring health status or physical condition. Personal assistance is only available for individuals who do not receive residential services or live in assisted living facilities and for whom training and skills development are not objectives or are provided through another program or service.

C. Service units and service limitations. The unit of service for personal assistance services is one hour. Each individual must have an emergency back-up caregiver in case the personal assistance aide does not show up for work as expected.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, personal assistance providers must meet additional provider requirements.

1. Personal assistance services shall be provided by an enrolled DMAS personal care provider or by a DMHMRSAS-licensed residential support provider and whose staff has passed the DMHMRSAS objective standardized test for residential support services.

2. For personal care providers who have a participation agreement with DMAS, the personal assistance provider must:

a. Employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all personal assistance aides. RNs must conduct the initial assessment and subsequent re-assessments.

(1) The supervising RN and LPN must be currently licensed to practice nursing in the Commonwealth and have at least 2 years of related clinical nursing experience which may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

(2) The RN supervisor must make an initial assessment comprehensive home visit prior to the start of care for all new individuals admitted to personal assistance. The RN supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

(3) The RN or LPN must make supervisory visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 - 90 days depending on individual's needs.

(4) The supervising RN or LPN summary must note:

(a) Whether personal assistance services continue to be appropriate;

(b) Whether the plan is adequate to meet the need or changes are indicated in the plan;

(c) Any special tasks performed by the aide and the aide's qualifications to perform these tasks;

(d) The individual's satisfaction with the service;

(e) A hospitalization or change in 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 or LPN's visit.

(5) Employ and directly supervise personal assistance aides who will provide direct care to personal assistance individuals. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS. Each aide must:

(a) Be able to read and write;

(b) Completion of a training curriculum consistent with DMAS requirements. Prior to assigning an aide to a consumer, the provider agency must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways;

(1) Registration as a Certified Nurse Aide;

(2) Graduation from an approved educational curriculum which offers certificates qualifying the student as a nursing assistant, geriatric assistance, or home health aide;

(3) Provider-offered training, which is consistent with the basic course outline approved by DMAS;

(c) Be physically able to do the work;

(d) 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

(e) Personal assistance aides may not be the parents of minor children, the individuals' spouses, or legally responsible relatives of the individuals. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care.

3. Provider inability to render services and substitution of aides.

a. When a personal assistance aide is absent and the agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to individuals. The agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or transfer the individual to another agency. The personal assistance agency that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization is necessary.

b. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures must apply:

(1) The personal assistance agency having individual responsibility must provide the RN or LPN supervision for the substitute aide.

(2) The agency providing the substitute aide must send a copy of the aide's signed daily records signed by the individual to the personal assistance agency having individual care responsibility.

(3) The provider agency having individual responsibility must bill DMAS for services rendered by the substitute aide.

c. If a provider agency secures a substitute aide, the provider agency is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS' requirements.

4. Required documentation in individuals' records. The provider agency must maintain all records of each personal assistance recipient. At a minimum these records must contain:

a. The ISP goals, objectives, and activities must be reviewed by the provider annually, or more often as needed with the individual receiving the services, and this review submitted to the case manager. In addition, the ISP goals, objectives, and activities must be reviewed by the provider quarterly, modified as appropriate and submitted to the case manager;

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

c. Nurses notes recorded and dated during any contacts with the personal assistance aide and during supervisory visits to the individual's home;

d. All correspondence to the individual and to DMAS;

e. Reassessments made during the provision of services;

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

g. All personal assistance aide records. The personal assistance 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; and

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

h. 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.

5. During the 60-day assessment period, documentation must confirm attendance and provide specific information regarding the individual’s response to various settings and supports as agreed to in the ISP

objectives. Assessment results should be available in at least a daily note or weekly summary.

12VAC30-120-248. Personal Emergency Response System (PERS).

A. Service description. PERS is a service which monitors individual safety in the home and provides access to emergency crisis intervention 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.

B. Criteria. PERS can be authorized when there is no one else in the home who is competent and continuously available to call for help in an emergency.

C. Service units and service limitations.

1. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month rental price set by DMAS. The one time installation of the unit includes installation, account activation, individual and caregiver instruction, and removal of equipment.

2. PERS services must be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, providers must also meet the following qualifications:

1. A PERS provider is a certified home health or personal assistance agency, a durable medical equipment provider, a hospital or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e. installation, equipment maintenance and service calls), and PERS monitoring.

2. The PERS provider must provide an emergency response center with fully trained operators who are capable of receiving signals for help from a individual's PERS equipment 24-hours a day, 365, or 366 days per year as appropriate; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.

3. A PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

4. The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices or medication-monitoring unit while the original equipment is being repaired.

5. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly. The PERS provider must test the PERS device monthly or more frequently as needed to ensure that the device is operational.

6. The PERS installation includes local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

7. A PERS provider must maintain a data record for each PERS individual at no additional cost to DMAS. The record must document all of the following:

   a. Delivery date and installation date of the PERS;

   b. Enrollee/caregiver signature verifying receipt of PERS device;

   c. Verification by a test that the PERS device is operational, monthly or more frequently as needed;

   d. Updated and current individual responder and contact information, as provided by the individual or the individual's care provider; and

   e. A case log documenting individual system utilization and individual or responder contacts and communications.

8. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

9. Standards for PERS equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark

on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the individual.

10. A PERS provider must furnish education, data, and ongoing assistance to DMHMRSAS and case managers to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the individual, caregiver, and responders in the use of the PERS service.

11. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

12. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment. The monitoring agency's equipment must include the following:

a. A primary receiver and a back-up receiver, which must be independent and interchangeable;

b. A back-up information retrieval system;

c. A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

f. A toll free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

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

14. The PERS provider shall document and furnish a written report to the case manager for each emergency signal which results in action being taken on behalf of the individual. This excludes test signals or activations made in error.

12VAC30-120-249. Prevocational Services.

A. Service description. Prevocational services are aimed at preparing an individual for paid or unpaid employment, but which are not job task-oriented. Prevocational services are provided to individuals who are not expected to join the regular work force or transition into competitive employment within a year, excluding supported employment programs. They include activities that are primarily directed at habilitative goals.

B. Criteria. In order to qualify for prevocational services, the individual shall have a demonstrated need for support in skills which are aimed towards preparation of paid employment which may be offered in a variety of community settings. Prevocational services are available only for persons whose productivity is less than 50% of minimum wage.

C. Service units and service limitations. Services are billed in units with the maximum number of 780 covered in a CSP year. Prevocational services can be provided in center or non-center based settings.

The plan of care must contain documentation regarding whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or in Special Education services through § 602 (16) and (17) of the Individuals with Disabilities Education Act. When services are provided through these sources, the plan of care shall not authorize them as a waiver expenditure. Compensation for prevocational services can only be made when the individual's productivity is less than 50 percent of the minimum wage.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, providers must also meet the following qualifications:

1. The provider of prevocational services must be a vendor of extended employment services, long-term employment services, or supportive employment services for DRS or be licensed by DMHMRSAS as a provider of day support services. These licensing requirements address standards for personnel, day program environments, and program and service content. They must also have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations.

2. For DMHMRSAS licensed programs, an ISP shall be consistent with licensing regulations. For non-DMHMRSAS licensed programs, an ISP, which contains, at a minimum, the following elements:

   a. The individual's strengths, desired outcomes, required or desired supports and training needs;

   b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

   c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

   d. All individuals or organizations that will provide the services specified in the statement of services;

   e. A timetable for the accomplishment of the individual's goals and objectives;

   f. The estimated duration of the individual's needs for services; and

   g. The individual or individuals responsible for the overall coordination and integration of the services specified in the CSP.

3. For individuals receiving training in prevocational skills, the lack of DRS or Special Education funding for the service must be documented in the record, as applicable. If the individual is older than 22 years, and therefore, not eligible for Special Education funding, documentation is required only for lack of DRS funding.

4. Documentation must confirm the individual's attendance, amount of time spent in services, and type of services rendered, and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives.

5. The ISP goals, objectives, and activities must be reviewed by the provider annually, or more often as needed with the individual receiving the services,

and this review submitted to the case manager. In addition, the ISP goals, objectives, and activities must be reviewed by the provider quarterly, modified as appropriate and submitted to the case manager.

6. A copy of the most recently completed DMAS 122.

12VAC30-120-250. Reevaluation of service need and utilization review. . This regulation shall only apply to those individuals who are receiving congregate residential services in DSS-licensed assisted living facilities that are seeking DMHMRSAS licensure pursuant to 12 VAC 30-120-230(C). This regulation shall only be in effect through September 15, 2002.

A. The Consumer Service Plan.

1. The Consumer Service Plan shall be developed by the case manager mutually with other service providers, the individual, consultants, and other interested parties based on relevant, current assessment data. The plan of care process determines the services to be rendered to individuals, the frequency of services, the type of service provider, and a description of the services to be offered. Only services authorized on the CSP by DMHMRSAS according to DMAS policies will be reimbursed by DMAS.

2. The case manager is responsible for continuous monitoring of the appropriateness of the individual's plan of care and revisions to the CSP as indicated by the changing needs of the recipient. At a minimum, the case manager shall review the plan of care every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

3. DMHMRSAS staff shall review the plan of care every 12 months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the CSP must be authorized by DMHMRSAS staff or DMAS.

B. Review of level of care.

1. The case manager shall complete an annual comprehensive reassessment, in coordination with the consumer, family, and service providers. If warranted, the case manager shall coordinate a medical examination and a psychological evaluation for every waiver recipient. The reassessment shall include an update of the assessment instrument and any other appropriate assessment data.

2. A medical examination shall be completed for adults based on need identified by the provider, consumer, case manager, or DMHMRSAS staff. Medical examinations for children shall be completed according to the recommended frequency and periodicity of the EPSDT program.

3. A psychological evaluation or standardized developmental assessment for children under six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation shall be required whenever

the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

C. Documentation required.

1. The case management agency must maintain the following documentation for review by the DMHMRSAS staff and DMAS utilization review staff for each waiver recipient:

a. All assessment summaries and CSP's completed for the recipient maintained for a period not less than five years from the
recipient's start of care.

b. All ISP's from any provider rendering waiver services to the recipient.

c. All supporting documentation related to any change in the plan of care.

d. All related communication with the providers, recipient, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties.

e. An ongoing log which documents all contacts made by the case manager related to the waiver recipient.

2. The individual service providers must maintain the following documentation for review by the DMHMRSAS staff and DMAS utilization review staff for each waiver recipient:

a. All ISP's developed for that recipient maintained for a period not less than five years from the date of the recipient's entry to waiver services.

b. An attendance log which documents the date services were rendered and the amount and type of service rendered.

c. Appropriate progress notes reflecting recipient's status and, as appropriate, progress toward the goals on the ISP.

12VAC30-120-251. Residential support services.

A. Service description. Residential support services shall be provided in the recipient's home, including the home of a relative or other person, a foster home, an assisted living facility, or a licensed group home. The service shall be designed to enable individuals qualifying for the mental retardation waiver to be maintained in living arrangements in the community and shall include: (i) training in or reinforcement of functional skills and appropriate behavior related to an individual's health and safety, personal assistance, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring the individual's health, nutrition, and physical condition; and (iii) assistance with personal assistance activities of daily living and use of community resources. Service providers shall be reimbursed only for the amount and type of residential support services included in the individual's approved

CSP. Residential support services shall not be authorized in the CSP unless the individual requires these services and these services exceed the care included in the individual's room and board arrangements for individuals residing in group homes, or, for other individuals, if these services exceed services provided by the family or other caregiver. Services will not be routinely provided for a continuous 24-hour period.

B. Criteria.

1. In order for Medicaid to reimburse for residential support services, the individual shall have a demonstrated need for supports to be provided by staff who are paid by the residential support provider.

2. In order to qualify for this service in a congregate setting, the individual shall have a demonstrated need for continuous training, assistance, and supervision for up to 24 hours provided by a licensed assisted living facility until September 15, 2002, or by a DMHMRSAS licensed residential setting provided by paid staff.

3. A functional assessment may be conducted to evaluate each individual in his home environment and community settings.

4. The residential support ISP must indicate the necessary amount and type of activities required by the individual, the schedule of residential support services, and the total number of hours per day of residential support.

C. Service units and service limitations. Residential supports shall be reimbursed on an hourly basis for time the residential support staff is working directly with the individual. Total monthly billing cannot exceed the total hours authorized in the CSP. The provider must maintain documentation of the date and times that services were provided, and specific circumstances that prevented provision of all of the scheduled services.

1. This service must be provided on an individual-specific basis according to the CSP and service setting requirements.

2. This service may not be provided to any individual who receives personal assistance or consumer-directed personal assistance services under the MR Waiver or other residential program that provides a comparable level of care.

3. Room and board and general supervision shall not be components of this service.

4. This service shall not be used solely to provide routine or emergency respite care for the parent or other caregivers with whom the individual lives.

5. Medicaid reimbursement is available only for residential support services provided when the individual is present and when a qualified provider is providing the services.

6. An individual's case manager shall not be the direct service staff person or the immediate supervisor of a staff person who provides residential support services to the individual.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, the provider of residential services must have the appropriate DMHMRSAS residential license. These licensing requirements address standards for personnel, residential program environments, and program and service content. They must also have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations.

Residential support services may also be provided in programs licensed by DSS (assisted living facilities) or in adult foster care homes approved by local DSS offices pursuant to state DSS regulations, for MR waiver recipients who reside in those facilities as of September 15, 2001. Services may continue to be provided for those recipients under the DSS license until September 15, 2002. The assisted living facilities must file an application for licensure by DMHMRSAS as a residential services provider by September 15, 2001. DSS-licensed providers who are providing residential services in assisted living facilities that do not file an application for licensure with DMHMRSAS by September 15, 2001, will be terminated as a provider of MR waiver residential support services. Assisted living facilities that are seeking licensure through DMHMRSAS to provide residential services will need to be licensed by September 15, 2002, in order to continue providing residential services to individuals in the MR waiver. In addition to licensing requirements, persons providing residential support services are required to pass an objective, standardized test of skills, knowledge, and abilities developed by DMHMRSAS and administered according to DMHMRSAS policies.

1. For DMHMRSAS licensed programs, an ISP must be consistent with licensing regulations.

2. For non-DMHMRSAS licensed programs, an ISP must contain the following elements:

a. The individual's strengths, desired outcomes; required or desired supports, or both; and training needs;

b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. The services to be rendered and the schedule of services to accomplish the above goals and objectives;

d. A timetable for the accomplishment of the individual's goals and objectives;

e. The individual or individuals or organization or organizations that will provide the services specified in the statement of services;

f. The estimated duration of the consumer's needs for services; and

g. The individual or individuals responsible for the overall coordination and integration of the services specified in the plan.

3. Documentation must confirm attendance and the amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives.

4. The ISP goals, objectives, and activities must be reviewed by the provider annually, or more often as needed with the individual receiving the services, and this review submitted to the case manager. In addition, the ISP goals, objectives, and activities must be reviewed by the provider quarterly, modified as appropriate and submitted to the case manager.

12VAC30-120-252. Respite care services.

A. Service description. Respite care services may include assistance with personal hygiene, nutritional support, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

B. Criteria. Respite care may only be offered to individuals who have a primary unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. Respite care is designed to focus on the need of the caregiver for temporary relief and to help prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent individual.

C. Service units and service limitations. Respite care services shall be limited to a maximum of 720 hours per year. This care shall not be provided to relieve group home or assisted living facility staff where residential care is provided in shifts. Respite care shall not be provided by Adult Foster Care/Family Care providers for an individual residing in that home. Training of the individual cannot be provided with Respite Care services. Individuals who are receiving consumer-directed respite and respite services cannot exceed 720 hours per calendar year combined.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, providers must meet the following qualifications:

1. Respite care services shall be provided by a DMAS enrolled personal care provider, a DMHMRSAS licensed-residential and supportive-residential provider of respite care services, a DMHMRSAS-licensed center based, in-home or out-of-home, respite care services provider; an approved DSS foster care home for children or adult foster home provider; or be registered with an organization licensed with DMHMRSAS as an individual provider of respite care services as defined in 12 VAC 35-102-10.

2. A personal care/respite care agency currently approved by DMAS to provide respite care services may provide MR waiver respite care services based in and from the home of the individual.

Individuals who provide care must meet the requirements of DMAS Personal/Respite Care Aides. Basic qualifications for Personal/Respite Care Aides include:

a. Physical ability to do the work;

b. Ability to read and write; and

c. Completion of a training curriculum consistent with DMAS requirements. Prior to assigning an aide to a consumer, the provider agency must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways;

(1) Registration as a Certified Nurse Aide;

(2) Graduation from an approved educational curriculum which offers certificates qualifying the student as a nursing assistant, geriatric assistance, or home health aide;

(3) Provider-offered training, which is consistent with the basic course outline approved by DMAS;

d. For personal or respite care providers who have a participation agreement with DMAS, the respite care provider must employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all respite care aides.

(1) The RN and LPN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, ICF/MR, public health clinic, home health agency, or nursing facility.

(2) Based on continuing evaluations of the aides' performance and individuals' needs, the RN or LPN supervisor shall identify any gaps in the aides' ability to function competently and shall provide training as indicated.

(3) The RN supervisor must make an initial assessment visit prior to the start of care for any individual admitted to respite care. The RN supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

(4) The RN or LPN must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(a) When respite care services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30-90 days based on the needs of the individual.

(b) When respite care services are not received on a routine basis, but are episodic in nature, the RN or LPN is not required to conduct a supervisory visit every 30-90 days. Instead, the nurse 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 assistance, the 30-90 day supervisory visit conducted for personal assistance may serve as the RN or LPN visit for respite care. However, the RN or LPN supervisor must document supervision of respite care separately. For this purpose, the same individual record can be used with a separate section for respite care documentation.

e. The RN or LPN must document in a summary note:

(1) Whether respite care services continue to be appropriate.

(2) Whether the supporting documentation is adequate to meet the individual's needs or if changes need to be made.

(3) The individual's satisfaction with the service.

(4) Any hospitalization or change in medical condition or functioning status.

(5) Other services received and the amount.

(6) The presence or absence of the aide in the home during the nurse's visit.

f. Inability to provide services and substitution of aides. When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to individuals.

(1) If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the individual's care to another agency. The personal assistance agency that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization is necessary.

(2) If no other provider agency is available who can supply an aide, the provider agency shall notify the individual or family so that they may contact the case manager to find another available provider.

(3) During temporary, short-term lapses in coverage, not to exceed two weeks in duration, a substitute aide may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following requirements apply:

(a) The respite care agency having individual responsibility is responsible for providing the supervision for the substitute aide.

(b) The respite care agency having individual care responsibility must obtain a copy of the aide's daily records signed by the individual and the substitute aide from the respite care agency providing the substitute aide. All documentation of services rendered by the substitute aide must be in the

individual's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the agency having individual care responsibility. The two agencies involved are responsible for negotiating the financial arrangements of paying the substitute aide.

(c) Only the provider agency that is authorized for services may bill DMAS for services rendered by the substitute aide.

(4) Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for individual respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another respite care provider agency that has the aide capability to serve the individual or individuals.

g. Required documentation for individuals' records. The provider agency must maintain all records of each respite care individual. These records must be separated from those of other services. At a minimum these records must contain:

(1) A consumer-focused ISP that includes the specific assistance that will be provided during the respite period and the approximate hours that will be allowed for each activity;

(2) Initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to supporting documentation by the RN supervisory nurse;

(3) Nurse's notes recorded and dated during significant contacts with the respite care aide and during supervisory visits to the individual's home;

(4) All correspondence to the individual and to DMAS and DMHMRSAS;

(5) Reassessments made during the provision of services; and

(6) Significant contacts made with family, physicians, the DMAS, and all professionals concerning the individual.

h. Respite care aide record of services rendered and individual's responses. The aide record must contain:

(1) The specific services delivered to the individual by the respite care aide and the individual's response.

(2) The arrival and departure time of the aide for respite care services only.

(3) Comments or observations recorded weekly about the individual. Aide comments must include, at a minimum, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered.

(4) The signature of the aide or family member, as appropriate, and the individual once each week to verify that respite care services have been rendered.

3. Documentation indicating the dates and times of Respite Care and the amount and type of service provided must be in the consumer's record.

4. The appropriate request for authorization must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur.

5. Respite care aides may not be the parents of minor children, the individuals' spouses, or legally responsible relatives for the individuals. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care.

12VAC30-120-253. Skilled nursing services.

A. Service Description. Skilled nursing services shall be provided for individuals with serious medical conditions and complex health care needs which require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the individual's home or other community setting on a regularly scheduled or intermittent need basis.

B. Criteria. In order to qualify for these services, the individual shall have demonstrate complex health care needs which require specific skilled nursing services ordered by a physician and which cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance. The plan of care must indicate that the service is necessary in order to prevent institutionalization and is not available under the State Plan for Medical Assistance.

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units. The services must be explicitly detailed in an ISP and must be certified by a physician as medically necessary to prevent institutionalization.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, participating skilled nursing providers must maintain the following documentation:

1. An ISP that notes the specific nursing services to be provided and the estimated amount of time required to perform these services. An ISP must specify any training of family or staff, or both, to be provided, including the recipient or recipients of the training and content of the training, consistent with the Nurse Practice Act;

2. Documentation of the determination of medical necessity by a physician prior to services being rendered;

3. Documentation of nursing license/qualifications of providers;

4. Documentation indicating the dates and times of nursing services and the amount and type of service or training provided;

5. The ISP must be reviewed by the provider with the individual receiving the services, and this review submitted to the case manager, at least annually or as needed. In addition, the ISP with goals, objectives, and activities modified as appropriate, must be reviewed quarterly and submitted to the case manager;

6. Documentation that the ISP has been reviewed by a physician within 30 days of initiation of services, when any changes are made to the ISP, and also reviewed and approved annually.

E. Skilled nursing services shall be provided by either a DMAS enrolled certified private duty nursing provider or a home health provider, by a registered nurse or licensed practical nurse, under the supervision of a registered nurse, licensed by the Commonwealth of Virginia and contracted or employed by DMHMRSAS-licensed day support or residential providers.

1. Skilled nursing services may not be the parents of minor children, the individuals' spouses, or legally responsible relatives for the individuals. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care.

2. A foster care provider may not be the skilled nursing services provider for the same persons to whom they provide foster care.

12VAC30-120-254. Supported employment services.

A. Service description.

1. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized supervision to enable an individual to maintain paid employment. Each CSP must contain documentation regarding whether supported employment services are available in vocational rehabilitation agencies through the Rehabilitation Act of 1973 or in special education services through 20 U.S.C. § 1401 of the Individuals with Disabilities Education Act. When services are provided through these sources, the CSP shall not authorize them as a waiver funded expenditure. Waiver service providers are reimbursed only for the amount and type of habilitation services included in the individual's approved plan of care based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of supported employment, not for the amount of time the individual is in the supported employment environment.

2. Supported employment can be provided in one of two models. Individual supported employment shall be defined as intermittent support, usually provided one-on-one by a job coach to a individual in a supported employment position. Group supported employment shall be defined as continuous support provided by staff to eight or fewer individuals with disabilities in an enclave, work crew, or bench work/entrepreneurial model. The individual's assessment and CSP must clearly reflect the individual's need for training and supports.

B. Criteria.

1. Only job development tasks that specifically include the individual are allowable job search activities under the MR waiver supported employment and only after determining this service is not available from DRS.

2. In order to qualify for these services, the individual shall have a demonstrated need for training, specialized supervision, or assistance in paid employment. Competitive employment at or above the minimum wage is unlikely for the individual, as he without this service, needs ongoing support, including supervision, training and transportation to perform in a work setting.

3. A functional assessment may be conducted to evaluate the individual in his work environment and related community settings.

4. The CSP must provide the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the individual's CSP.

C. Service units and service limitations.

1. Supported employment for individual job placement will be billed on an hourly basis.

2. Group models of supported employment (enclaves, work crews and entrepreneurial model of supported employment) will be billed at the unit rate.

3. For the individual job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the individual is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, specific provider qualifications are:

1. Supported employment shall be provided by agencies that are DRS vendors of supported employment services.

2. Individual ineligibility for supported employment services through DRS or Special Education services must be documented in the individual's record, as applicable. If the individual is older than 22 years, and therefore not eligible for Special Education funding, documentation is required only for lack of DRS funding. Acceptable documentation would include a copy of a letter from DRS or the local school system or a record of a phone call (name, date, person contacted) documented in the case manager's case notes, Consumer Profile/Social assessment or on the supported employment ISP. Unless the individual's circumstances change, the original verification can be forwarded into the current record or repeated on the ISP or revised Consumer Profile/Socia l Assessment on an annual basis.

3. There must be supporting documentation that contains, at a minimum, the following elements:

a. The individual's strengths, desired outcomes, required/desired supports and training needs;

b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All individuals or organizations that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the individual's goals and objectives.

f. The estimated duration of the individual's needs for services; and

g. Individuals responsible for the overall coordination and integration of the services specified in the plan.

4. The ISP must be reviewed by the provider with the individual receiving the services, and this review submitted to the case manager, at least annually or as needed. In addition, the ISP with goals, objectives, and activities modified as appropriate, must be reviewed quarterly and submitted to the case manager..

12VAC30-120-255. Therapeutic consultation.

A. Service description. Therapeutic consultation is available under the waiver for Virginia licensed or certified practitioners in psychology, psychiatry, social work, occupational therapy, physical therapy, therapeutic recreation, rehabilitation, and speech/language therapy. Behavior consultation may be performed by professionals based on the professionals' work experience, education, and demonstrated knowledge, skills, and abilities. These services may be provided, based on the individual's CSP, for those individuals for whom specialized consultation is clinically necessary to enable their utilization of waiver services. Therapeutic consultation services may be provided in the individual's home or any other community setting. Only behavior consultation may be offered in the absence of any other waiver service when the consultation is determined to be necessary to prevent institutionalization. Therapeutic consultation service providers are reimbursed according to the amount and type of service authorized in the CSP based on an hourly fee for service.

B. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the CSP cannot be implemented effectively and efficiently without such consultation from this service.

1. The individual's ISP must clearly reflect the individual's needs, as documented in the social assessment, for specialized consultation provided to caregivers in order to implement the ISP effectively.

2. Therapeutic consultation services may neither include direct therapy provided to waiver individuals nor duplicate the activities of other services that are available to the individual through the State Plan of Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the ISP. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-214 and 12 VAC 30-120-215, professionals rendering therapeutic consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation shall be rehabilitation engineers or certified rehabilitation specialists.

1. Documentation requirements for therapeutic consultation. The following information is required:

a. Identifying information: individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for the ISP; and quarterly review dates, if applicable;

b. Targeted objectives, time frames, and expected outcomes;

c. Specific consultation;

d. The ISP for therapeutic consultation; and

e. The expected outcomes.

2. Monthly notes shall include:

a. Summary of consultative activities for the month;

b. Dates, locations, and times of service delivery;

c. ISP objective or objectives addressed;

d. Specific details of the activities conducted;

e. Services delivered as planned or modified; and

f. Effectiveness of the strategies and individuals' and caregivers' satisfaction with service.

3. Contact notes shall include date, location, and time of each consultative service contact; type of activities and hours of service provided; and persons to whom activities were directed.

4. Quarterly reviews are required by the service provider if consultation extends three months or longer, are to be forwarded to the case manager, and must include:

a. Any revisions to the therapeutic consultation ISP;

b. Activities related to the therapeutic consultation supporting documentation;

c. Individual status and satisfaction with services; and

d. Consultation outcomes and effectiveness of support plan.

5. If consultation services extend less than three months, the provider must forward monthly contact notes or a summary of them to the case manager for the quarterly review.

6. A written support plan, detailing the interventions and strategies for staff, family, or caregivers to use to better support the individual in the service.

7. A final disposition summary must be forwarded to the case manager within 30 days following end of this service and must include:

a. Strategies utilized;

b. Objectives met;

c. Unresolved issues; and

d. Consultant recommendations.

12VAC30-120-256 through 12 VAC30-120-257. Reserved.

12VAC30-120-258. Urgent criteria. The CSB will determine, from among the individuals included in the urgent category, who should be served first, based on the needs of the consumer at the time a slot becomes available and not on any predetermined numerical or chronological order.

A. The urgent category will be assigned when the individual is in need of services because he is determined to be at significant risk. Assignment to the urgent category may be requested by the individual, his legal guardian, or caregiver. The urgent category may be assigned only when the individual or legal guardian would accept his preferred service if it were offered. Only after all individuals in the Commonwealth who meet the urgent criteria have been served can individuals in the non-urgent category be served. In the event that a CSB has a vacant slot and does not have an individual who meets the urgent

criteria, the slot can be held by the CSB for 90 days, in case someone in an urgent situation is identified. If no one who meets the urgent criteria is identified within 90 days, the slot will be made available for allocation to another CSB in the Health Planning Region (HPR). If there is no urgent need at the time that the HPR is to make a regional re-allocation of a waiver slot, the HPR shall notify DMHMRSAS. DMHMRSAS shall have the authority to re-allocate said slot to another HPR or CSB where there is unmet urgent need. Said authority must be exercised, if at all, within 30 days from receiving such notice.

B. Satisfaction of one or more of the following criteria shall create a presumption that the individual is at significant risk and indicate that the individual should be placed on the Urgent Need of Waiver Services List:

1. Both birth or adoptive parents are 55 years or older, or in the case of a single parent, that parent is 55 or older;

2. The individual is living with a person other than the birth or adoptive parent or parents who are providing the service voluntarily and without pay and the person who has been providing care indicates that he can no longer care for the person with mental retardation;

3. There is a clear risk of abuse, neglect, or exploitation;

4. Either of the birth or adoptive parents, or if the single parent has a chronic or long term physical or psychiatric condition or conditions which limit significantly his ability to care for the individual with mental retardation;

5. Individual is aging out of publicly funded residential placement or otherwise becoming homeless; (exclusive of children who are graduating from high school) or

6. The individual with mental retardation lives with the birth or adoptive parent or parents and there is a risk to the health or safety of the individual, parent, or other individual living in the home due to either of the following conditions:

a. The individual's behavior or behaviors present a risk to himself or others which cannot be effectively managed by the parents even with generic or specialized support arranged or provided by the CSB; or

b. There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the parent even with generic or specialized supports arranged or provided the CSB.

12VAC30-120-259. Reevaluation of service need and utilization review.

A. The Consumer Service Plan (CSP).

1. The CSP shall be developed by the case manager mutually with other service providers, the individual, the individual's family caregivers, consultants, and other interested parties based on relevant, current assessment data. The CSP process determines the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered. Only services authorized on the CSP by DMHMRSAS according to DMAS policies will be reimbursed by DMAS.

2. The case manager is responsible for continuous monitoring of the appropriateness of the individual's supporting documentation and revisions to the CSP as indicated by the changing needs of the individual. At a minimum, the case manager must review the CSP every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

3. Any modification to the amount or type of services in the CSP must be authorized by DMHMRSAS staff or DMAS.

B. Review of level of care.

1. The case manager shall complete an annual comprehensive reassessment, in coordination with the consumer, family, and service providers. If warranted, the case manager shall coordinate a medical examination and a psychological evaluation for the individual. The reassessment shall include an update of the assessment instrument and any other appropriate assessment data.

2. A medical examination must be completed for adults based on need identified by the provider, consumer, case manager, or DMHMRSAS staff. Medical examinations for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

3. A psychological evaluation or standardized developmental assessment for children under six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation shall be required whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

C. Documentation required.

1. The case manager must maintain the following documentation for a period of not less than five years prior to the last day of service for review by the DMHMRSAS staff and DMAS utilization review staff for each waiver recipient:

a. All assessment summaries and all CSPs completed for the recipient.

b. All ISPs from any provider rendering waiver services to the recipient.

c. All supporting documentation related to any change in the CSP.

d. All related communication with the providers, recipient, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties.

e. An ongoing log which documents all contacts made by the case manager related to the waiver recipient.

2. The individual service providers must maintain documentation necessary to support services billed. Review of individual-specific documentation shall be conducted by DMHMRSAS staff and DMAS utilization review staff. This documentation shall contain, up to and including the last day of service, all of the following:

a. All ISP's developed for that recipient and maintained for a period of not less than five years.

b. An attendance log which documents the date services were rendered and the amount and type of services rendered.

c. Appropriate data or progress notes reflecting recipient's status and, as appropriate, progress toward the goals on the ISP.

d. Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

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12VAC30-120-260. Medallion definitions.