Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-120–211 through 12 VAC 30-120-249 (REPEALED) 12VAC 30-120-1000 et seq.
Regulation title	Waivered Services
Action title	Intellectual Disability Waiver
Date this document prepared	March 14, 2012

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

In addition to repealing the existing regulations and re-promulgating newly formatted regulations, this suggested final regulation also includes changes to meet federal requirements resulting from the waiver renewal process. CMS requires states to assure the health and welfare of individuals enrolled in a home and community based waiver and to assure financial accountability and administrative authority in program operations. The major changes resulting from the federal waiver renewal process, and reflected herein, include: (i) the addition of person-centered planning concepts; (ii) provision for a standardized assessment instrument to document an individual's needs and required supports; (iii) provision of an annual risk assessment process; (iv) provision of service facilitation as a covered service instead of an administrative procedure for all individuals enrolled in the waiver; (v) automation of the patient pay information process; (vi) addition of statewide uniform standards of urgent care criteria for use by the community services boards, and; (vii) addition of nomenclature changes to reflect current terms used throughout the waiver renewal.

Changes that were made in the previous emergency regulations, as well as in the previous proposed regulations, included the use of current terminology (e.g., replace "mental retardation" with "mental retardation/intellectual disability"), changing the name of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to the Department of Behavioral Health and Developmental Services (DBHDS), adding definitions for person-centered terms such as "Person-Centered Planning," "Individual Support Plan," and "Plan for Supports," adding the requirement for an annual risk assessment, requiring an additional comprehensive assessment to be completed every three years on a DBHDS-approved assessment tool, and changing the requirement that individuals participating in the consumer-directed service model must have a services facilitator (SF) to that they may choose to work with a SF at their option.

No significant changes have been made in these final regulations over the agency's current policies set out in 12 VAC 30-120-211 *et seq*. The individual eligibility criteria, the covered services, and provider reimbursement are the same. The changes that are recommended in these suggested final regulations are as follows: (i) all references to MR/ID have been changed to simply ID; (ii) a definition has been added for in-home residential support services in response to public comment; (iii) in the definition for services facilitator reference is made to collaborating with the case manager in response to public comment; (iv) provider monitoring of the electronic system for patient pay information has been changed from periodically to monthly in response to public comment; (v) collaborative development of the Individual Support Plan between the individual and the case manager is emphasized in response to public comment; (vi) annual expenditure amounts for assistive technology and environmental modifications have been restored to $5,000 in response to public comment; (vii) the six-month time blocks for respite services has been removed in response to General Assembly action; (viii) CSB case managers, working with the individual and family/caregivers, will have only 30 days to initiate services before the individual will have to be referred back to the local department of social services for possibly an eligibility re-determination; (ix) the knowledge, skills, and abilities required for persons to enroll with DMAS as services facilitators (as now set out in 12 VAC 30-120-225) are being added back in to these regulations rather than being incorporated by reference from a guidance document, and; (x) respite assistants are being required to have two references in their work record, rather than one as was proposed, as is set out in the current regulations 12 VAC 30-120-233 D. Other clarifying text changes are being made in response to commenters' questions.

Other non-substantive changes are recommended to improve clarity and readability. Another non-substantive change that is recommended is the replacement of references to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) with Intermediate Facilities for the Intellectually Disabled (ICF/ID). In 2010, Public Law 111-256, known as Rosa's Law, amended statutory language providing for changing references of mental retardation and mentally retarded to intellectual disability and intellectually disabled. In the spirit of Rosa's Law, CMS proposed to amend several of its regulations (FR 76:205, p 65917, 10/24/2011) with the preferred terminology. In effect, this is a terminology change only and does not broaden nor narrow the scope of services. DMAS received numerous advocate comments requesting this terminology change.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency or board taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Agency Background document with the attached amended regulations for Waivered Services: Intellectual Disability Waiver (12 VAC 30-120-1000 through 12 VAC 30-120-1090; 12 VAC 30-120-211 through 12 VAC 30-120-249 to be repealed) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

_3/14/2012____ _/s/ Cynthia B. Jones_____

Date Cynthia B. Jones, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Medicaid waivers are authorized by § 1915 (c) of the *Social Security Act* and are intended be a less costly way, as compared to institutionalization, of caring for qualifying individuals' medical, social, and habilitative needs. This statute section permits the waiver of certain fundamental Medicaid requirements, such as state-wideness and comparability of the amount, duration, and scope of services. The state-wideness standard states that covered services must be available throughout the entire Commonwealth. The comparability of amount, duration, and scope of services standard states that services covered for mandatory groups of eligible persons cannot be of a lesser degree than those covered for optional groups and covered services must be provided to the same degree for all persons within each covered group. Waiver programs are permitted, pursuant to § 1915 (c) of the *Social Security Act*, to cover unique services to specifically designated populations of Medicaid individuals based on their medical, social and habilitative support needs.

This program is a waiver of federal comparability of services requirement because these covered waiver services are only provided to persons who qualify for this waiver program by being at

risk of institutionalization. Most of DMAS' home and community based care waivers are designed, due to the diagnoses of the various target populations, as medical care models. This ID waiver is more uniquely a social service than a medical model, at the urging of DBHDS and the advocacy community.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons it is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

These regulations are required in order to meet the Centers for Medicare and Medicaid Services (CMS) requirements for the renewal of the Intellectual Disability (ID) Waiver (previously referred to as the Mental Retardation Waiver). DMAS covers these services pursuant to a waiver of certain federal requirements, permitted by application to CMS, the federal Medicaid authority. CMS approved the request for the renewal effective July 1, 2009; the current ID waiver will expire June 30, 2014.

The ID Waiver program provides supportive services in the homes and communities of persons with diagnoses of intellectual disability or children younger than the age of six years who are at risk of developmental delay. This program permits these individuals to safely remain in their homes and communities rather than being institutionalized in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The ID Waiver program currently supports 8,937 slots (one slot per waiver individual).

DMAS collaborates with the Department of Behavioral Health and Developmental Services (DBHDS), formerly known as the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), in the administration of this waiver. DBHDS has worked closely with DMAS on the referenced waiver submission as well as these suggested final regulations.

This waiver program does not have a direct impact on the health, safety, and welfare of citizens of the Commonwealth. It does benefit those individuals who qualify for this important waiver by supporting them in their lives in their homes and communities.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The regulations affected by this action are the Waiver Programs, specifically Intellectual Disability Waiver regulations. The regulations at 12VAC 30-120-211 through 120-249 are recommended for repeal and the regulations at 12VAC 30-50-1000 *et seq.* are being newly promulgated.

Prior to the latest referenced federal approval of waiver changes (during the routine waiver renewal process), this program was entitled the Mental Retardation Waiver. The same services were covered as are contained in these suggested final regulations. The same waiver individual income and resource eligibility standards are used. The provider requirements are essentially also the same. The differences in these suggested final regulations over the current regulations are discussed below.

CMS now requires that states use person-centered planning in their waiver programs to ensure that individuals enrolled in the state's home and community based waivers fully participate in the planning for their services and supports. Virginia's Systems Transformation Grant and other complementary efforts have resulted in the development of certain core elements of a person-centered planning process for Virginia. Person-centered planning goes beyond the traditional individualized planning processes used in the waiver. The person-centered approach relies much less on the service system and focuses on the individual receiving waiver services and supports. To accomplish person-centered planning across Virginia, these regulations incorporate the essential definitions and activities needed to implement this concept. These definitions include person-centered planning, individual support plan, plan for supports and use of a standardized assessment tool, which is discussed below. These definitions and activities further ensure these individuals' health, safety, and welfare are ensured and meet CMS' requirements for waiver renewal.

As part of the person-centered planning process, DBHDS has identified one standardized assessment tool (the Supports Intensity Scale (SIS)) and schedule (every three years) to ensure consistency across Virginia in identifying individuals' needs for waiver supports and services. DBHDS will publish guidance documents for the ID Waiver that provide further information for this standardized assessment tool.

CMS and Virginia place great importance on the health, safety, and welfare of individuals enrolled in waiver programs. To this end, an annual risk assessment was included in the waiver renewal. This risk assessment will be conducted, and risk mitigation will be incorporated, into each individual support plan as a component of person-centered planning.

Virginia, since 1997, has permitted certain of its covered waiver services (personal care assistance, respite care, and companion services) to be provided in a consumer-directed model in addition to the more traditional agency-directed model. The agency-directed model uses enrolled provider agencies who hire nurses, nurse aides, and assistants to render services to Medicaid individuals according to a provider-developed schedule and staffing assignments. The consumer-directed model permits the individual who is enrolled in the waiver to be the employer (hiring, training, and firing) of his own assistant and to schedule the assistant's services (work schedule) consistent with the individual's needs, as they are documented in the individual's approved plan of care now known as the Individual Support Plan.

Virginia's ID Waiver regulations have historically required that an individual choosing the consumer-directed model for the delivery of personal care assistance, respite care, and companion care services also must receive the services of a services facilitator. In CMS' most recent review of Virginia's ID Waiver application for renewal, CMS instructed the Commonwealth that be-

cause services facilitation is a waiver service, waiver individuals have the right to choose whether or not to receive services facilitation. Therefore, in these suggested final regulations Virginia changed services facilitation to an optional service in the waiver.

To ensure that the essential tasks related to the delivery of consumer-directed services continue to be performed, these regulations propose that the individual or the family/caregiver, as appropriate, perform those tasks (e.g., development of a plan of supports, submission of the plan for prior authorization, record documentation, etc.) themselves when services facilitation is not chosen by the individual or his family/caregiver. Also, as "services facilitation" is included in the waiver renewal as an optional service, rather than as an administrative activity, a definition is added herein. In situations when objective determinations, that no providers exist who can render the services required by the individual, must be made, and the supporting documentation prepared, the case manager (an employee of the local Community Services Board/Behavior Health Authority) is herein assigned the responsibility.

CMS further directed Virginia to modify the process currently used to fill ID Waiver slots to ensure the uniformity of the statewide process. CMS has required that Virginia, through DBHDS, develop uniform, statewide guidelines to be applied by community services boards (CSBs) and behavioral health authorities (BHAs) to identify those urgent waiting list individuals who are most in need of services when waiver slots become available. These suggested final regulations incorporate the DBHDS' authority to accomplish this federal directive.

These regulations include DMAS' conversion to an electronic information exchange system between the local departments of social services, DMAS, and enrolled ID service providers for determination of the patient pay requirement for waiver services.

In order to be found eligible for these waiver services, an individual must meet the definition of an institutionalized individual so that eligibility determination uses the more liberal rules for institutionalized individuals. This is appropriate because individuals using these waiver services would otherwise require care in an institution, specifically for this waiver an Intermediate Care Facility for the Intellectually Disabled (ICF/ID). For the purposes of this definition, continuity of eligibility is broken when absence from an institution or non-receipt of waiver services lasts for more than 30 days. Therefore, in spite of the numerous comments received to change the proposed-stage 30 days to 60 days (as is the current practice) after Medicaid eligibility is determined to consider options and engage service providers, DMAS is unable to accommodate this suggested change.

The regulations, 12 VAC 30-120-1040(H)(3) and (H)(4) provide for the changes to or termination of services in non-emergency and emergency situations. Providers are typically required to afford the individual and family/caregiver 10 days advance notice of changes along with a reminder of the right to appeal the change. In emergency situations, situations in which there can be imminent harm to either the individual enrolled in the waiver or the provider's staff, the harmful situation must first be changed to avert the harm. In such situations, these suggested final regulations require the immediate notification of the appropriate authorities by both the case manager and the provider consistent with the statutory provisions for mandatory reporters of abuse or neglect.

The proposed regulation also includes technical changes to facilitate the enrollment and service provision processes in response to stakeholder input.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If there are no disadvantages to the public or the Commonwealth, please indicate.

This action poses no disadvantages to the public or the Commonwealth. These proposed changes make these regulations more consistent with the needs of individuals receiving services, providers of those services, and the two affected agencies' missions. The regulatory requirements have been clarified when appropriate to facilitate their application and to promote better understanding for users. The provisions have also been modified to reduce implementation costs for providers and the agency whenever possible.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

The use of all references to mental retardation have been recommended for removal.

Section number	Requirement at proposed stage	What has changed	Rationale for change
1000 through 1090	Reference is made to ICF/MR in numerous locations in proposed regulations.	ICF/MR was changed to ICF/ID	To conform to PL 111-256's terminology change. Does not represent either an expansion or reduction of service. Change made in response to public comments.
1000 Definitions	This definition was not proposed.	Definition of in-home residential support services and IDOLS have been added	Agency response to public comment and for clarity.
	This collaboration was not provided for in the proposed stage.	Collaboration required between services facilitator and case manager has been provided for consistent with person-centered planning concepts.	Agency response to public comment.
	Definition of QMRP set out educational and license requirements.	QMRP definition has been changed to reference the citation of the licensing agency.	Since DMAS is not a licensing agency, deference to DBHDS' licensing standards is appropriate.
	Definition of services facilitator did not require collaboration with the case manager.	Definition has been modified to require this collaboration.	Agency response to public comment.
1005	Individual enrolled in ID waiver who is determined to be eligible for the IFDDS waiver must be added to the IFDDS' waiting list and terminated from the ID waiver.	Provision has been removed.	Inconsistent with long standing agency policy and regulations.
1010 B	The 4 criteria that individuals seeking ID waiver services must meet did not specify the assessment instrument.	The approved assessment instrument, the SIS, is specified.	The use of one assessment instrument statewide was federally approved in the waiver application thereby permitting uniform and consist evaluations resulting in equal treatment of all applicants consistent with federal law.
1010 D 1 & 3	Item did not refer to the DBHDS electronic system that captures waiver enrollment information.	Reference to IDOLS is added. Written enrollment confirmation is being removed because the previous paper system has been replaced with an electronic one.	Change made as it improves communications between local agencies and DBHDS by reducing response times. Eliminates the need for the

			requested timeline in the regulations.
1010 D 3 c	Item did not provide for the individual to give informed consent.	The individual, family/caregiver, and case manager must sign the ISP to indicate concurrence.	Agency response to public comment.
1010 D 4 & 5	Services must be initiated in 30 days.	Calendar has been added to qualify the 30 days time period.	Clarifying text change.
	Providers are required to periodically monitor the system for changes in patient pay amounts.	Periodically has been changed to monthly. This system is being modified to give case managers access to this needed information.	Agency response to public comment.
1010 E 1	Individual Support Plan must be developed by the case manager and the individual.	The word collaboratively has been added to emphasize how the case manager is required to conduct this process consistent with person-centered planning concepts.	Agency response to public comment.
1010 E 2	Time standards are established for repeated SIS assessments based on the individual's age.	Individuals who are 16 years of age and older are to be reassessed every 3 years while younger individuals every 2 years.	Agency response to public comment.
1020 (all sections)	Blocks of time for specified services were described as being in hours and seconds.	Seconds have been changed to minutes.	Correction of a typographical error and agency response to public comments.
1020 A 4	For waiver individuals to be allowed to select consumer direction as the mode of service delivery for personal care, companion services or respite services, they must be able to guarantee their safety and welfare.	Guarantee has been changed to assure.	Agency response to public comments.
1020 A 5	Establishes requirements for voluntary/involuntary disenrollment from consumer directed services.	The services facilitator who initiates an involuntary disenrollment from consumer direction must inform the individual's case manager about this change.	Agency response to public comment concerning collaboration between these two persons.
1020 A 7	Addresses uniform requirement to obtain prior authorization for all covered services.	This is current agency policy for this waiver and not a new requirement in these regulations.	Added for clarity of requirements.
1020 B	Contains requirements and limits for the Assistive Technology service.	Maximum amount of service to be covered is restored to existing $5,000.	The 2011 General Assembly funded this service at this amount. Agency response to public comment.
1020 C	Companion services are defined as not involving hands-on care.	Routine has been added to hands-on care to permit a companion to assist the individual in an emergency situation.	Agency response to public comment.
1020 E	Day support services block of time was described in hours and seconds.	Seconds has been changed to minutes.	Correction of a typographical error. Agency response to public comment.

1020 F	(i) Environmental modifications (EM) are only permitted when without them the individual would require institutionalization. (ii) Maximum calendar year expenditure limit was $3,000. (iii) Receipt of EM is tied to receipt of at least one other waiver service and case management.	(i) Reference to institutionalization has been removed. (ii) Limit was changed to $5,000. (iii) Receipt of case management not a prerequisite for EM because all individuals enrolled in the waiver receive case management. Receipt of at least one other waiver service is retained as a policy currently in effect.	(i) All of this waiver's services meet these standards so it is duplicative to state it in this particular service. (ii) This service was funded at the $5,000 level by the 2011 General Assembly. (iii) Agency response to public comment.
1020 I	Prevocational services time block was stated in hours and seconds.	Seconds was changed to minutes.	Correction of a typographical error. Agency response to public comment.
1020 J	Residential support services are offered in both congregate settings and in-home settings.	In-home residential support is not to substitute for primary care from the individual's family.	It was an oversight in the proposed stage to not address in-home residential support. Examples of exceptional reasons for the need for 24-hour service can be: to prevent individual from removing medical/safety equipment, manic episodes, sexual aggression or chronic self-injury.
1020 K	(i) Allowed hours for respite services were to be divided into six-month segments. (ii) Respite was to be covered to only prevent the breakdown of the unpaid caregiver.	The six-months segments have been removed. Reference to the breakdown of the caregiver is removed.	Agency responses to public comment.
1020 L	In Services Facilitation and the consumer-directed service model, a non-specific reference to agency guidance document was used. Discontinuing consumer directed services was provided. Employer of record (EOR) duties included everything except being required to complete hiring packets for assistants in a timely/ accurate manner	(i) The non-specific reference was changed to the specific document required. (ii) Advance notice and appeal rights must be afforded to affected individuals when changes are made in the receipt of services. (iii) Case managers are being required to create the necessary documentation concerning family members rendering companion services. (iv) Timely/ accurate completion of hiring packets has been added to EOR's duties.	(i) Conformance with Registrar's Style Manual. (ii) Conformance to federal requirements. (iii) In situations where the individual declines services facilitation, a disinterested third party must create the justification for why a family member would be eligible to provide (and be reimbursed by DMAS) companion services. (iv) Agency response to public comment.
1020 N	Supported employment services are described as being intensive and intermittent.	These qualifiers have been removed. Job development tasks can include more than just searches.	Agency response to public comment.

1020 O	Behavioral consultation, as part of therapeutic consultation, was covered only if it was necessary to prevent institutionalization.	Prevention of institutionalization has been recommended for removal.	This describes all of the services covered in this waiver so it is duplicative to have it here. Agency response to comment.
1020 P	Transition services are only covered for an individual currently institutionalized who wishes to move to the community.	Policy was not changed but language was clarified.	Improved readability of regulations. Agency response to public comment.
1040 C 1, 6, 17,	Provider notification to DMAS/DBHDS of changes in information. List of additional statutes that providers must comply with. Criminal record checks for assistants/ companions.	Changes in information relating to the provider enrollment contract are required to be submitted. Fair Housing Amendments Act has been added. A barrier crime to hiring assistants/companions would be having abused/neglected adults who are 18 years of age if incapacitated.	Agency responses to public comments. Language clarification.
1040 F	Providers are required to use specified forms to document services.	(i)Reference is removed to successor forms and agency guidance documents. (ii)Phase-in language is removed.	(i)Conformance to Registrar's Style Manual. (ii)Language will be outdated by the time regulations become effective so is no longer necessary.
1040 H	In emergency situations, there can be changes to or terminations of services.	The standard that must be met is endangerment of health, safety or welfare.	Language clarity.
1060	Provider requirements for all services are set out.	Provider requirements by service have been linked to that service's description and coverage limits.	For improved clarity and regulatory application across multiple sections.
1060 F	Reference to QMRP work experience and education.	Work experience and educational standards are removed.	DMAS is not a licensing agency and therefore has adopted the work experience and educational standards of DBHDS (the licensing agency) for these professionals.
1060 I	Personal assistance (both consumer-directed and agency directed) provider requirements.	Individual enrolled in the waiver must agree to all changes that are made to his Plan for Supports.	Agency response to public comment and consistent with person centered planning.
1060 K	Prevocational services providers must document all of the individual's activities and circum-stances.	Providers must prepare and maintain documentation.	Language clarification.
1060 M	When respite services are episodic, the supervisor/ services facilitator must make home visits at the start of services and then again during the respite period. Respite assistant	(i) The term 'respite period' refers to the service authorization period approved for this service. DMAS has changed its terminology of 'prior authorization' to 'service authorization'. (ii) Job references for respite assistants is changing to	(i) Agency response to public comments and language clarification for consistency with operational phrases. (ii) Corrects an agency oversight.

	was required to have one previous job reference.	two for consistency with agency-directed personal care assistants and with current policy 12 VAC 30-120-233 D. .	
1060 Q	If therapeutic consultation services captured in the Plan for Supports requires changes, these changes must be reviewed by the case manager with the individual and family/caregiver.	The individual/family caregiver must also agree to the changes.	Agency response to public comments and consistent with principles of person centered planning.
1070 B	Reimbursement for individual and group supported employment services set out.	Agencies responsible for this rate setting are identified.	Agency response to public comments.
1070 C	Reimbursement for AT and EM services.	Outdated date and language is removed.	Improved language clarity.
1088 B	Assignment to urgent waiting list.	(i) Reference to the specific guidance document is added. (ii) Added that case manager must notify in writing the affected individual/ family/caregiver within 10 days of placement on the list.	(i) Conformance to Registrar's Style Manual. (ii) Agency response to public comment.

Other editorial changes to clarify regulatory language, in response to questions received, are being made. Generic references to agency guidance documents are recommended for removal as such Incorporations by Reference are not necessary and do not strengthen these regulations. In the two remaining Incorporations by Reference, they have been specifically named/dated consistent with the Registrar's Style Manual.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.

DMAS' proposed regulations were published in the September 26, 2011 *Virginia Register* for their comment period from September 26, 2011, through December 9, 2011. Comments were received from 16 individuals representing: Didlake, Our Choices Advocacy Group, Virginia Board for People with Disabilities, VA Office for Protection and Advocacy, Fairfax-Falls Church CSB, VA Medicaid Network (representing Autism Society of Central Virginia, Center for Family Involvement, Parent to Parent of Virginia, Peninsula Autism Society, Virginia Association of Centers for Independence Living, Virginia Board for People with Disabilities, and Virginia Office for Protection and Advocacy), vaACCSES, The ARC of Virginia, Henrico Area Mental Health & Developmental Services, The Choice Group, St. John's Community Services, Virginia Poverty Law, VCU Partnership for People with Disabilities, and three individuals. A summary of the comments received follows:

Commenter	Comment	Agency response

Commenter	Comment	
Didlake	This commenter stated that the DMAS' waiver regulations should be completely aligned with Individual Supported Employment (ISE) as administered by the Dept. of Rehabilitative Services. The commenter stated that DMAS should cover non-face-to-face documented interventions and collateral contacts including, but not limited to, meetings and set up, travel, job development, indirect advocacy, and narratives/reports. Supported Employment providers cannot provide these functions without being reimbursed by DMAS. "Failure to make this recommended change will result in many individuals who are eligible to receive ISE under the waiver to be denied the services they deserve."	DMAS will further evaluate the differences between its policies and those of the Dept. of Rehabilitative Services in response to this comment. Appropriate changes may be made during the waiver application renewal process.
Our Choices Advocacy Group	This commenter stated that DMAS should remove the words 'mental retardation' from the regulations.	Now that the relevant federal statute has been changed, DMAS concurs and has made this change.
Individual	This commenter stated that DMAS should remove the words 'mental retardation' from the regulations.	Now that the relevant federal statute has been changed, DMAS concurs and has made this change.
Individual	This commenter stated that DMAS should remove the words 'mental retardation' from the regulations.	Now that the relevant federal statute has been changed, DMAS concurs and has made this change.
Virginia Board for People with Disabilities	1. Regulations are not clear in sec. 1005 regarding children transitioning from the ID waiver to the Family Developmental Disability (IFDDS) waiver. A diagnosis of ID cannot be established before the age of 6 due to testing limitations. The regs provide for transition to the IFDDS waiver up until the 7th birthday which can be problematical in areas where there are waiting lists for psychologists' services. Testing accommodations, critical for persons with ID, need to be included. The case manager should be required to review	1. Families are free to begin the process of assembling documentation for this transition in the child's fifth year while reserving the required psychological evaluation to the sixth year. DMAS' cannot dictate to psychologists how they schedule their appointments. DMAS has clarified that this window of time refers to applying for the IFDDS waiver and not necessarily being accepted into it. When a child no longer

	with the child's parents all other Medicaid services for which the child may be eligible upon disenrollment from the ID waiver.	qualifies for waiver services, he may lose his Medicaid eligibility altogether because the income standards for waiver eligibility are based on higher institutional standards while non-waiver services are not. DMAS will provide for this in its revised provider manual.
	2. Section 1010 should require the case manager to conduct a reassessment of individuals on waiting lists in addition to providing the choice between institutional placement and waiver services. (ii) Case managers should be required to monitor individuals' needs at least quarterly because health issues or other circumstances could change during the year thereby causing someone on the non-urgent waiting list to meet urgent criteria. (iii) A description of the medical information expected from the required examination should be stated.	2. Since case managers are employees of local CSBs/ BHAs, those agencies have the authority and responsibility to dictate job duties. (ii) This is already provided for in the regulations (see §1010 E). (iii) Most physicians use standardized forms for examinations that capture information about all human body systems as a matter of standard good medical practice.
	3. In section 1020, the regulation's use of 'waiver individual' is not in keeping with person centered principles. The board suggested instead the use of 'person enrolled in the waiver'.	3. This suggested change has been partially made in the suggested final text but DMAS is retaining the noun 'individual' as who receives waiver services. The noun 'person' has been used throughout these regulations to refer to providers' employees.
	4. For the three conditions that disqualify an individual from receiving consumer-directed services under this waiver, the board recommended a description of the assessment or other process to be used to determine the disqualification.	4. This process will be detailed in the agency's relevant guidance document.
		5. The term 'guaranteed' has

	5. Remove the word 'guaranteed' from requirement for the back-up emergency plan.	been changed to 'assured' in the interest of best protectting the health, safety, and welfare of individuals enrolled in this waiver.
	6. The board recommended that an appeal process be identified as available to someone who is disqualified for consumer-directed services.	6. Individuals who elect to appeal their disenrollment from consumer-direction will be handled through the agency's usual client appeal process. (12 VAC 30-110-10 et seq.)
	7. Remove the term 'breakdown' from the description of respite services as this presents an unreasonable standard.	7. The Agency has made this change in response to this comment.
	8. The service limit text for respite services is more restrictive than budget bill language. Personal caregiver or the individual's circumstances could warrant more than 240 hours of respite care in a six months period and less in the following six months.	8. The six-month period time limit for the use of respite services has been removed in response to this comment.
	9. The board also urged DMAS and the Department of Behavioral Health and Developmental Services to consider implementation of a 'universal' waiver based on functional criteria as a way streamline application processes for individuals with disabilities and provide administrative cost savings.	9. DMAS and DBHDS are giving further consideration to a universal waiver in light of federal funding limitations and requirements.
VA Office for Protection and Advocacy (VOPA)	1. VOPA agreed that an employer of record (EOR) may not feel it is necessary to check references of assistants, especially if the assistant to be hired is a family member or well-known acquaintance. In light of the fact that most abuse/neglect is perpetrated by someone known to the victim, VOPA recommended that it could be beneficial to require additional documentation that the waiver individual is made aware of these risks and has agreed to assume the risk.	1. DMAS agrees with VOPA's position that abuse/neglect can frequently be perpetrated by persons well known to the individual and has therefore elected to retain the criminal background check requirements even for family members/other persons well known to the individual.
	2. VOPA recommended that 12 VAC 30-120-1040 (H)(4) be strengthened to ensure that an	2. DMAS cannot force a provider to retain an indi-

	emergency discontinuation of services is not based on a manifestation of the individual's disability. This section should also clarify which entity is to notify the various other affected entities in emergency situations.	vidual in his service who is harmful to himself or the providers' staff or property. Individuals are afforded the right of appeal of changes in their care. Notification details are set out in agency guidance documents.
	3. VOPA recommended that 12 VAC 30-120-1088 should detail an individual's option to request assignment to the urgent waiver waiting list category. DMAS should also include a time frame by which community services boards/behavioral health authorities should respond to such requests.	3. An individual's option to request urgent waiting list placement is already provided for. DMAS agrees that a time frame is needed for the notification and has changed the regulations accordingly.
	4. VOPA supported DMAS' designation of a system-wide standardized assessment instrument, the Supports Intensity Scale.	4. DMAS appreciates VOPA's support of this new policy.
Fairfax-Falls Church CSB	1. There is confusion about some inconsistent information in the proposed regulations. There is confusion about date ranges which can span fiscal years, calendar years, and the previously used individualized service plan years. There is also confusion about the application of the new limits for assistive technology and respite services and the use of a calendar year date range. This commenter requested that simple examples be developed by DBHDS to demonstrate the application of these new policies.	1. Changes cannot be made to return AT/EM services to the individual's plan year. This policy caused significant difficulty for DMAS in tracking total AT/EM expenditures per individual. This issue was cited as a deficiency when DMAS' Division of Internal Audit audited this waiver. The date range for respite services must remain on a state fiscal year due to the related legislative mandate. (Chap. 890, Item 297 WW). DBHDS will be developing the requested examples.
	2. The reduced time frame for the initiation of waiver services needs clarification as some families struggle to evaluate options and details of service options within the existing 6 months now permitted.	2. The 30-days to initiate services are tied to the Medicaid eligibility determination process as discussed more fully below.

	3. The proposed regulation language does not specify that an individual's ID diagnosis must be made prior to age 18. Many families who seek waiver services may not have the requisite diagnostic documentation dated prior to the individual's 18th birthday.	3. This issue is addressed in the agency's guidance document for the ID waiver.
	4. With regard to the use of the SIS assessment instrument, there needs to be clarification as to whether the 3-year cycle also applies to children. There is no mention in these proposed regulations of the use of the SIS for residents of the state's training centers.	4. The three-year cycle does not apply to children. The regulations have been clarified on this point to show that children will be on a two-year cycle. These regulations do not address the use of the SIS for residents of training centers be-cause those facilities are regulated by DBHDS and not DMAS. Furthermore, an individual cannot be in a state training center simultaneously with receiving waiver services.
	5. Support Coordinators are paid a monthly fee, including the time involved with the SIS. The recommendation was that service providers who participate in the assessment process resulting in a SIS score be compensated through waiver reimbursement (DMAS' funds). There is concern that the Commonwealth will base future reimbursement rates or levels on SIS scores. If this is the intent, this should be disclosed so providers/individuals can prepare or offer testimony.	5. DMAS has no appropriations to additionally compensate Support Coordinators who are employees of CSBs/BHAs for their preparation/ evaluation of the SIS form. It is not the intent of these regulations to base reimbursement on SIS levels. Such a significant change in this waiver would first require CMS approval of such a change to the waiver.
	6. There would be a cost to CSBs and providers to fulfill requirements for electronic information exchanges among DMAS and DSS. This commenter stated that there is a history of unfunded mandates being imposed by DMAS and DBHDS for which no reimbursement is available.	6. This verification of patient pay amounts must be handled on a monthly basis as individual eligibility and related patient pay can, conceivably, change that frequently. See additional dis-

		cussion of this issue below.
	7. While the leveraging of EPSDT funding is cost effective, the process details are confusing. The proposed text places the responsibility on the support coordinator to decide to whom the authorization should be submitted. The commenter recommended retaining the decision process within DBHDS and not assigning it to the local CSBs.	7. The commenter is referred to DBHDS' Bulletin No. 7 (dated 5/2011).
	8. This commenter stated that the prevalence of individuals electing to opt out of the service facilitation process is larger within just this one CSB service area than contained in this change.	8. The commenter may be correct about the prevalence point. However, DMAS was required by CMS to make Services Facilitation optional.
	9. Day support services have been redefined. The proposed regs have eliminated 'training' and 'assistance' and substituted 'skill building, supports, and safety supports'. 'This is acceptable as long as the level of assistance typically provided to recipients can now be defined as supports and safety supports. The removal of 'community integration' from this service's definition could be a problem for providers and recipients who benefit from community integration activities. This commenter further asked if such activities could be 'rebranded' in service plans as skill building?	9. These requirements have not changed; only the descriptive language to make it more person-centered has changed. Community integration is still contained in the reg's Service Description. (see §1020 E) Examples of safety supports are: support during panic attacks, before/during/after blood sugar episodes, recovery periods after medical issues, episodes of self-injury.
	10. A unit block has replaced the service unit. Providers have requested a definition of rounding when increments of time are provided.	10. The issue of how to round time periods up or down will be addressed when the provider manual is revised after the regulations become effective.
	11. Since service providers shall be reimbursed only for the amount and level of day support included in the individual's Plan for Supports, it suggests that preparation (administering and analyzing) of the SIS would NOT be reim-	11. Additional Medicaid reimbursement for preparation, analyzing, and administering the SIS is not available at this time.

	burse-able. This commenter contended that there could be room for interpretation if the Plan for Supports references SIS development as a key component of the service plan. 12. For several day services (day support, pre-vocational, and supported employment), there is language that states that DMAS will only cover these services after the determination that the services are not available from the Dept. of Rehabilitative Services (DRS). Currently, this determination is done once at the time of waiver enrollment. Is this practice to be continued or will this determination have to be made each time that a day service is requested? 13. This commenter requested that the statement be added to these regulations that the DRS reimbursement rates specific to each provider as approved by DRS applies to Supported Employment. 14. This commenter recommended that the language for Therapeutic Consultation needed revision. This service is still limited to just consultation and service providers who implement costly behavioral or other therapeutic interventions without additional compensation are affected.	12. Nothing has changed in the proposed regs over the existing policies. The original verification can be forwarded. New determinations are indicated only if there are major changes in the individual's condition. 13. DMAS added a definiton of in-home residential support in response to this comment. 14. Additional reimbursement for Therapeutic Consultation is not available. Consultation is only that by definition and does not include behavioral or other therapeutic (treatment) interventions. Providers who render costly behavioral or other therapeutic interventions without service authorization do so at their own risk.
VA Medicaid Waiver Network	1. The final regulations should refer to this waiver as the Intellectual Disability Waiver. Maintaining the use of the antiquated term 'mental retardation' is inconsistent with the Commonwealth's commitment to person-centered language. 2. For in-home residential support, a definition of this service needs to be added.	1. This change has been made in response to this comment. 2. This change has been made in response to this comment.

	3. For residential support services, the definition should clarify how this service is different from congregate and in-home residential services.	3. This change has been made in response to this comment.
	4. The proposed new definition of 'skilled nursing services' is clear and improved over the current regulations.	4. DMAS appreciates this comment.
	5. For transition services, the definition should be expanded to provide that the individual can be transitioning from either an institution or a certified provider-operated living arrangement.	5. This is already covered in the regs' Service Description.
	6. For the required evaluation before the age of seven, DMAS should allow a standardized developmental assessment to substitute for a psychological evaluation.	6. This is already permitted by DBHDS. CSBs/BHAs should check with the state agency if there is a question about substitute assessments.
	7. For transferring from the ID waiver to the IFDDS waiver, include a clear timeline for DMAS to make a determination of whether an individual is appropriate for transfer and if an IFDDS slot is available.	7. Families are free to begin the process of assembling documentation for this transition in the child's fifth year while reserving the required psychological evaluation to the sixth year. DMAS has clarified that this window of time refers to applying for the DD waiver and not being accepted into it. Providing a 'clear timeline' would not solve the issue of the lack of an adequate number of slots.
	8. Clarify that an individual cannot be enrolled in or receive services simultaneously from multiple home and community based waiver programs.	8. This change has been made. An individual whose name is on a waiver's waiting list is not considered to be enrolled in that waiver.
	9. Clarify whether or not services can be reimbursed before the approval/authorization pro-	9. No, this is not permitted as already set out in §1010

	cesses have been completed.	D.6.
	10. The regulations should specify when/how informed consent is required before services are provided or revised.	10. DMAS will revise the relevant agency guidance documents to address this issue.
	11. The waiting list process and language is improved.	11. DMAS appreciates this comment.
	12. This commenter recommended establishing a timeline by which DBHDS must respond to requests from case managers to enroll individuals in this waiver.	12. DBHDS has now instituted an electronic enrollment system: ID Online System so time delays have been eliminated.
	13. The case manager's required annual contacts of persons on waiting lists is important. The case manager should also be required to assess the individual's current needs and his placement on the urgent/non-urgent waiting list.	13. This requirement is already provided for in the regs as well as the agency's guidance documents.
	14. A new requirement should be added that written notification be provided to the individual if their waiting list status is changed.	14. This change has been made and is already provided for in the agency's guidance documents.
	15. If an individual is not eligible for Medicaid or private insurance, then a medical exam should not be required until he is enrolled in Medicaid. Individuals should not be required to make personal payments for requirements established by DMAS in order to receive Medicaid services. This required exam should be delayed until the individual's Medicaid eligibility is established.	15. A medical exam is not required for the Medicaid eligibility determination. (see 12 VAC 30-120-1010 D) The medical exam is required to have occurred within one year from the start of waiver services.
	16. If the designated collector of patient pay is the employer of record (EOR) for consumer-directed services, then the case manager should be required to periodically monitor for change in patient pay amounts. If there are changes in the patient pay amount, the case manager should notify the EOR.	16. The electronic system for monitoring changes in patient pay amounts has been modified so that case managers can directly access this information. This change has been made in response to public comment.

	17. For informed consent for services, there should be included an agreement in writing by the individual.	17. This change has been made.
	18. For modifications to the amount or type of services, there should be included an agreement in writing by the individual.	18. This change has been made.
	19. The requirement for the 'guarantee' of the health, safety, and welfare of the individual should be removed. This requirement is impractical.	19. This change has been made.
	20. Assistive technology should continue to be authorized by the plan year rather than the calendar year as proposed. Service authorizations should all be by plan year to avoid the possibility of case managers and providers being overwhelmed in the October-December quarter with requests for services.	20. The change to AT being authorized by the calendar year has resulted from a DMAS audit. This recommended change cannot be made because DMAS is not able to otherwise automate its tracking of how much of this benefit an individual has used.
	21. Correct the annual limit for assistive technology to be $5,000.	21. This change has been made.
	22. Add 'routine' to the provision of companion services.	22. This change has been made.
	23. Remove reference to avoiding institutionalization for assistive technology as all waiver services must meet this standard.	23. This change has been made.
	24. Correct the annual limit for environmental modifications to be $5,000.	24. This change has been made.
	25. Remove from the environmental modifications (EM) text the reference to receiving targeted case management. This requirement is not unique to EM but applies to all covered waiver services. EM should remain on the plan year instead of changing to the proposed calendar year.	25. This change concerning targeted case management has been made. The change about retaining EM services by the plan year cannot be accommodated.

	26. Add reference to the Fair Housing Amendments Act to the list of excluded modifications.	26. This change has been made.
	27. Permit the upkeep and maintenance of an item not purchased through the ID waiver to be covered as an EM as this may be a more cost effective option than purchasing a new item.	27. DMAS is not able to accommodate this change at this point but will give this recommendation further consideration during the waiver renewal process.
	28. Remove 'and family caregiver' from the back-up plan for personal assistance as the family caregiver may be the ones serving as the backup.	28. This language has been modified for improved clarity.
	29. Allow personal assistance services to be provided to people who live in congregate residential settings and to people who need skill development.	29. DMAS is not able to accommodate this change at this point but will give this recommendation further consideration during the waiver renewal process.
	30. Add language that describes the difference(s) between congregate and in-home residential services.	30. This change has been made.
	31. Add language explaining how room and board arrangements would include residential supports and why they would do so. The separation of housing from services is important to many individuals/families who do not want to be beholden to the housing provider if they elect to change service providers.	31. As DMAS understands this comment, this appears to be a licensing issue which is beyond DMAS' purview to address in these regulations.
	32. Allow individuals to receive personal assistance when they are away from the congregate facility.	32. This expansion of personal assistance is not feasible at this point but will be given further evaluation during the waiver renewal process.
	33. In §1020 K, remove 'in order to avoid institutionalization of the individual' as this applies to all waiver services.	33. This change has been made.

	34. Retain the current policy of allowing individuals to use respite hours whenever needed during the year instead of being restricted to six months increments.	34. This change has been made.
	35. Regarding §1020 K (5), this item should be removed as the subsection applies to both consumer-directed and agency-directed respite. If the statement remains, an additional statement should provide that agency-directed respite must meet the same standards as consumer - directed respite.	35. This language has been clarified.
	36. Language should be added stipulating the responsibilities of the EOR should the individual elect to not use services facilitation.	36. See § 1060 N.
	37. Remove the language that services facilitators review timesheets as they are submitted electronically and may not be available when the home visit occurs.	37. The system containing timesheet information is being modified to make this information available to services facilitators at their desks.
	38. Clarify whether the term 'case manager' refers to an employee of the CSB/BHA or to the local agency.	38. This change has been made.
	39. Allow the individual's case manager to be the services facilitator if the individual so prefers. Role of case manager should be described if the individual elects to not use services facilitation.	39. Such an overlapping of duties would represent a conflict of interest due to the case manager's overall responsibility to ensure the appropriate and accurate content of the Individual Support Plan. The family/ caregiver acts in the place of the services facilitator if the individual elects to not have this service.
	40. Modify the requirement that the EOR check assistants' references/criminal records. The EOR may not feel it necessary to check the reference of a family member or a well-	40. DMAS understands how this could be seen as a time and effort saver. However, in light of VOPA's comment

	known acquaintance. Add a requirement that the EOR complete the required hiring packets.	about how frequently the perpetrators of violence are known to the victim, DMAS elects to not make this change. The EOR completing the hiring packet change has been made.
	41. Clarify how management training will occur if the individual using consumer-directed services elects to not receive services facilitation.	41. Such individuals, by declining to receive services facilitation, will be expected to educate themselves on all requirements using DMAS published guidance materials.
	42. Update the description to clarify that individuals who meet home health criteria may also need ID waiver skilled nursing services.	42. DMAS cannot reimburse for duplicated services. An individual would receive skilled nursing services from either home health or through the waiver but not both simultaneously.
	43. For transition services, replace the word 'funding' with 'services'.	43. This language has been clarified.
	44. Add reference to the Fair Housing Amendments Act to the list of statutes with which providers must comply.	44. This change has been made.
	45. Change 'shall' to 'may' with regard to individuals being responsible for costs of his waiver services incurred during his appeal action.	45. This change cannot be made as individuals who do not prevail in appeals must reimburse for services received during their appeal processes. This requirement applies to all Medicaid individuals for all services.
	46. Clarify which entity will maintain the listed documentation if there is no services facilitator.	46. The individual's family/ caregiver is responsible for this by virtue of declining services facilitation.

	47. Remove requirement that the services facilitator (SF) maintain identifying information for the assistant or assistants. The SF does not need to know who the assistant is and it is important to maintain a clear separation of roles to reinforce the responsibilities of each entity.	47. Since the services facilitator is required to check timesheets and perform training, this change cannot be accommodated.
	48. Retain current language that makes it the responsibility of the SF to document why other providers are not available if family members living under the same roof are going to provide companion services. If the individual elects to not receive services facilitation, then the individual forfeits choice and must use the case manager.	48. The proposed text is the same as the current policy and the regulatory language has been clarified.
	49. Clarify the reference to agency directed requirements that this subsection's language applies only to agency-directed personal assistants.	49. This change has been made.
	50. In §1060, add requirement for consumer-directed personal assistants to submit documentation for background checks to the State Police and Child Protective Services. This requirement is already in §1020 so it should be added to §1060 to make this list complete and improve compliance.	50. This change has been made.
	51. A citation should be added to where the reader can find the referenced MR/ID waiver requirements.	51. This change has been made.
	52. Requirements for documentation of employee management training should be the same in each subsection.	52. This change has been made.
	53. Requirements for all 3 consumer-directed services should be standardized.	53. This change cannot be made because the 3 services are slightly different.
	54. Modify the language to show that the requirement is to document that the individual is not eligible for prevocational or supported employment services through IDEA.	54. To make this change would result in this requirement being more restrictive. DMAS declines to make this change.

	55. Define respite period.	55. This change has been made.
	56. Changes to the plan should be agreed to by the individual not just reviewed.	56. This change has been made.
	57. Add that services will not duplicate services required by the Fair Housing Amendments Act.	57. This additional reference has been added.
	58. Add a description as to how applicants are notified about requesting assignment to the urgent waiting list.	58. The regs already state that individuals are notified in writing and this will be further clarified in the manual.
	59. Change term 'children' to individual.	59. This change is declined because in the context of its use in the proposed text, 'children' is more clear.
vaACCSES	1. Use of the phrase 'waiver program' is confusing. The word 'program' should be removed. The terms 'enrolled' versus on a 'waiting list' should be further defined in the provider manual.	1. The change to remove 'program' has been made. Further definition of terms in the manual will be done.
	2. There are inconsistent time frames between initiation and/or completion of SIS with the existing 60-day enrollment timeline.	2. This change cannot be made because it relates to eligibility determinations as is further discussed below.
	3. Change time period for service initiation from the proposed 30 days to 60 days.	3. The 30-day services initiation time period is driven by federal requirements. See further discussion below.
	4. The providers' time requirement for monitoring the DMAS-designated system should be consistent between the regulations and manual.	4. This change has been made.
	5. Limits on covered services: change term 'seconds' to 'minutes'.	5. This change has been made.
	6. Providers of day support should be compen-	6. This change is not made

	sated for SIS analysis and administration as this is not now reimbursable. SIS development as a key component of the Plan for Supports should be an allowable billable service.	as there are no appropriations for this. This change would first have to be approved in the context of federal approval of the waiver application and additional funding would first have to be approved by the General Assembly.
	7. The commenter supported the change from unit of time to unit block of time. Further definition/explanation in the manual and additional training is needed.	7. DMAS appreciates this support. Upon the completion of these regulations, DMAS will update its relevant guidance documents for consistency with the new regulations.
	8. Statement that 'prevocational services are to be provided when the individual's compensation for work performed is less than 50% of the minimum wage' should be removed as this is a disincentive for an individual to be in prevocational versus day support. Many states no longer include this provision with federal approval.	8. This limitation is contained in CMS' manual instructions for the waiver application. VA does not ignore inconvenient federal policies and therefore is retaining this limitation in spite of the commenter's assertion that other states ignore this policy.
	9. Remove reference to 'intensive' in §1020 N Supported Employment. As the overall definition for both individual and group, it should be as flexible as possible to allow for fluctuations in service needs. Delete 'intermittent'. 'Collateral contacts by providers' needs to be further defined in the provider manual. 'Eight or fewer' is problematic and rigid to some employment circumstances so should be removed. This should be further defined in manual to provide flexibility for employment opportunities and circumstances as well as staff to client ratios. The wording 'specifically include' and 'search' is problematic and does not allow for maximum flexibility in job development tasks on behalf of the individual. The regulations	9. These three changes have been made. The manual will be updated consistent with the final effective regulations. The 'eight or fewer' policy will be re-considered in the waiver application renewal process. 'Specifically include' and 'search' have been removed. The change concerning the

	provide for group models of supported employment but no provision is made for individual supported employment rates. 10. 'Seconds' should be changed to 'minutes' in the supported employment service units and definitions.	inclusion of individual supported employment rates has been made. 10. This change has been made.
The ARC of VA	1. The term 'mental retardation' should be removed as it is counter to the Common-wealth's effort to transform into a person-centered community based system of care for individuals. 2. Assistive technology and environmental modifications should be authorized by the plan year rather than by the calendar year as proposed. 3. The annual limit for assistive technology and environment modifications should be $5,000. 4. Maintain the policy that permits individuals to use respite hours throughout the year as needed. Remove the language that permits individuals to use 240 hours of respite every six months. 5. This commenter endorsed the comments from the VA Medicaid Waiver Network.	1. This change has been made. 2. This change cannot be accommodated because this change was made as a result of an audit. DMAS was not able to track an individual's total AT/EM expenditures when they were based on the plan year. 3. These changes have been made. 4. This change has been made. 5. DMAS appreciates the collaborative efforts of the various interested entities.
Henrico Area Mental Health & Development Services	1. This commenter requested that QMRPs who do not meet the new qualifications be grandfathered in and that parameters for this be provided. 2. Language should be added to the definition for services facilitator that ensures collaboration with the case manager. 3. Does the prohibition of the provision of MR/ID services outside the Commonwealth	1. This requested change concerns licensing and is therefore beyond the purview of these regulations. 2. This change has been made. 3. This question is outside the purview of these regula-

	preclude the future interstate compact between DSS in different states?	tions.
	4. Change the provision to initiate the SIS within 30 days or allow a longer time to complete the SIS to 60 days.	4. This requested change cannot be accommodated due to federal eligibility restrictions. See further discussion below.
	5. Define 'periodically' as it relates to monitoring the DMAS designated system for changes [in patient pay amounts]. This commenter stated that every local DSS agency does things differently and they should be informed of this requirement.	5. 'Periodically' has been changed back to 'monthly' since changes in patient pay amounts can occur on a monthly frequency.
	6. Add language that the case manager is informed whenever the services facilitator initiates involuntary enrollment of services.	6. This change has been made.
	7. This commenter asked who provides the management training for the EOR if there is no services facilitator.	7. The EOR will be expected to learn everything that is required from DMAS and DBHDS publications and guidance materials if services facilitation is declined.
	8. This commenter asked about the definitions of 'intermittent' and 'ongoing' as regarding supported employment services.	8. 'Intermittent' has been removed in these final regulations. 'Ongoing' means actions that occur on a regular basis, if not every day then almost every day.
	9. Clarification is needed for the phrase 'any change' with regard to the requirement for immediate notification to DMAS/DBHDS.	9. This has been clarified in the regulations.
	10. This commenter requested clarification regarding the phrase 'date of documentation completed' concerning case managers responsibility for completion of the DMAS-225 form.	10. This refers to DMAS' universal requirement that whenever documentation is prepared for a service for which Medicaid reimbursement will be sought that it be signed and dated by the person preparing the docu-

		mentation.
Individual	The requirement that half of the available respite hours be used in a six-months period with no carryover makes it harder for families to care for their loved ones. Recommend removal of this restriction.	This change has been made.
The Choice Group	1. For supported employment services, 'intensive' is not the appropriate word to use here. Ongoing supports may be either 'intensive' or periodic depending upon the individual's circumstances and employer requirements. As the overall definition for both individual and group, it should be as flexible as possible to allow for fluctuations in service needs. 2. Delete 'intermittent'. 3. 'Collateral contacts by providers' needs to be further defined in the provider manual. 4. 'Eight or fewer' is problematic and rigid to some employment circumstances so should be removed. This should be further defined in manual to provide flexibility for employment opportunities and circumstances as well as staff to client ratios. 5. The wording 'specifically include' and 'search' is problematic and does not allow for maximum flexibility in job development tasks on behalf of the individual. 6. The regulations provide for group models of supported employment but no provision is made for individual supported employment rates. 7. 'Seconds' should be changed to 'minutes' in the supported employment service units and definitions.	1 & 2. 'Intensive' and 'intermittent' have been removed from the regulations. 3. This will be addressed when the manual is updated subsequent to the regulations becoming final. 4. This will be further evaluated at the point of the waiver application renewal. 5. These changes have been made. 6. This change has been made. 7. This change has been made in response to public comments.
St. John's Community Services	1. Community integration needs to be returned to the definition of 'skill-building'. There is inconsistency between the regulations and manual on the issue of providers being re-	1. This is addressed in the service description. Monitoring of patient pay amounts has been changed

	quired to monitor the DMAS-designated system for changes in patient pay amounts (periodically in regulations) and (monthly in the manual). Clarification is needed of text that suggests that preparation/administering/ analyzing of the SIS is not reimbursable. The SIS should be considered a reimbursable service. There needs to be clear communication about the future use of SIS scores as it relates to future reimbursement rates.	back to monthly in these regulations. Separate reimbursement for the preparation/ administering/ analyzing of the SIS is not available. There are no current plans to tie reimbursements to SIS scores.
	2. The commenter suggested that DMAS consider the inclusion of an in-home residential support service definition as a separate, distinct service area.	2. A new definition has been added for this.
	3. This commenter suggested that Transition Services be re-worded to include a definition including set-up expenses for individuals transitioning from either institutions or licensed/ certified provider-operated living arrangements to a private residence living arrangement.	3. This information is located in the proposed regs' services description.
	4. Assistive technology should be authorized by the plan year rather than the proposed calendar year. The annual limit should be corrected to be $5,000.	4. AT cannot be authorized on the plan year but the annual limit has been changed back to $5,000.
	5. Annual limit for environmental modifications should be corrected to be $5,000. These services should be authorized on the plan year rather than the proposed calendar year.	5. EM cannot be authorized on the plan year but the annual limit has been changed back to $5,000.
	6. Prevocational services should be removed as it is a service that limits individuals who seek services and contrary to the employment first concepts if individuals work at less than 50% of the minimum wage.	6. This will be evaluated further at the point of the waiver application renewal.
	7. The new respite limit should be changed to just a single cap of 480 hours that can be used across a year. Seconds needs to be changed to minutes. This commenter supported the use of the 'unit block' as the billing unit.	7. Both of these changes have made.

	8. Waiver service initiation should be modified from the proposed 30 days expectation to a more flexible and reasonable 60 days. This allows for the completion of necessary activeties/assessments and ensures that proper supports are in place.	8. DMAS understands this concern but cannot make this change as it relates to federal eligibility requirements. See further discussion below.
	9. Clarify that a waiver individual cannot be enrolled in more than one waiver at a time.	9. This change has been made.
	10. For Supported Employment, clarify that waiver reimbursement is provider specific as approved by DRS and posted in DMAS' rate schedule. Delete 'intensive' and change 'ongoing support' to clarify that it can be intensive or periodic depending on the individual's/ employer's needs/circumstances. Remove the term 'intermittent'.	10. These changes have been made.
	11. The term 'collateral contacts by providers' requires further definition. The wording in subsection N.3.a. is problematic in that it does not permit maximum flexibility in job development tasks on behalf of the individual.	11. This will be further clarified when the manual is updated consistent with the final regulations.
	12. The phrases 'specifically include' and 'search' should be deleted. Job search is only one aspect of job development.	12. These changes have been made.
Virginia Poverty Law	1. This commenter endorsed the comments submitted on behalf of the Virginia Medicaid Waiver Network.	
	2. 12 VAC 30-120-1040(H)(3) and (H)(4) should either be removed from the final regulations or modified. The proposed provisions violate federal regulations and due process guarantees which require that Medicaid individuals be given at least 10 days advanced notice of any action to suspend, reduce, modify, or terminate their Medicaid services. The proposed provisions permit providers to make unilateral decisions to terminate Medicaid services without the required notice nor appeal rights.	2. The agency has provided for appeal rights in the non-emergency situation contemplated by 12 VAC 30-120-1040(H)(3) with the 10-days notice before the change. However, in (H)(4) this change cannot be made. Emergency situations are by definition emergencies and involve endangerment to either the waiver individual,

		family members, or the provider personnel. There must be a mechanism to terminate the emergency situation, short of direct, immediate harm to someone. Individuals enrolled in the waiver are permitted to appeal all changes.
VCU Partnership for People with Disabilities	1. The use of the term 'mental retardation' should be removed now that federal law has changed and in order to respect citizens with disabilities.	1. This change has been made.
	2. Modify the definition of 'person-centered planning' to better follow person-centered principles. Modify the definition of 'personal profile' to provide that the individual leads the development of the profile.	2. This change has been made.
	3. With regard to transferring from the ID waiver to the DD waiver, a timeline needs to be included for the transfer determination to be made. Without such a timeline, the family and case management organizations are unaware if the process is proceeding in a timely manner.	3. Families are free to begin the process of assembling documentation for this transition in the child's fifth year while reserving the required psychological evaluation to the sixth year. DMAS has clarified that this window of time refers to applying for the DD waiver and not being accepted into it. Adding a timeline would not resolve the issue of the lack of an adequate number of DD waiver slots for the community need.
	4. Specifics regarding how/when consent is required before services are provided or revised should be added.	4. This will be addressed in the agency guidance document which is to be revised.
	5. Case managers should annually contact waiting list individuals/ families to discuss their choice between an ICF/MR facility and the ID waiver. In addition, the case manager	5. This requirement is already provided for in the regs as well as the provider manual.

	should assess the individual's current needs and placement on the urgent/non-urgent waiting list.	
	6. Development of the individual support plan must involve the person and his supporters at the start of the process and must emphasize that the person drives the plan.	6. This change has been made.
	7. Documents in the planning process should be revisited when plan updates are made or the individual supports change. The tools used in the planning process should be used when updating the plan.	7. This is already required in § 1010 E.
	8. Include a statement that the initial plan for services requires a written agreement by the individual.	8. This change has been made in response to public comments and will be further addressed when the manual is revised.
	9. Include a statement that any modifications to the amount/type of service requires the individual's written agreement.	9. This change has been made in response to public comments and will be further addressed when the manual is revised.
	10. The statement that the back up emergency plan must 'guarantee' the health, safety, and welfare of the individual should be removed or the guarantee requirement should be applied to all services.	10. This has been changed.
	11. With regard to companion services, the term 'routine' should be added.	11. This change has been made.
	12. With regard to the back-up plan for personal assistance, remove 'and family/ caregiver' as the family/caregiver may be the back up plan.	12. This language has been clarified.
	13. Personal assistance should be provided to persons who live in congregate residential settings and who need skill development. Companion services can be provided to a person living in a congregate setting. Personal assis-	13. DMAS and DBHDS will evaluate this recommendation further during the waiver renewal process.

	tance may be needed when the individual is away from the congregate residential setting.	
	14. Remove the language: 'in order to avoid institutionalization of the individual'.	14. This change has been made.
	15. Maintain the current policy of allowing people to use their respite hours when needed throughout the year. Remove the 6 months restriction.	15. This change has been made.
	16. Add language that the EOR will be responsible for designated items if the individual elects to not receive services facilitation.	16. The regulations already provide for this in § 1020 L.
	17. Clarify if the 'case manager' is an employee of the CSB/BHA that provides case management.	17. This change has been made.
	18. Modify the requirement that the EOR check references of assistants. Even though it is generally a best practice to check references, if the EOR is hiring a family member/well known acquaintance, the EOR may feel it is unnecessary to check references on such an individual.	18. DMAS understands how this could be seen as a time and effort saver. However, in light of VOPA's comment about how frequently the perpetrators of violence are known to the victim, DMAS declines to make this change out of an abundance of caution.
	19. Add a requirement that the employer complete hiring packets.	19. This change has been made.
	20. With regard to transition services, replace the term 'funding' with 'services'.	20. This change has been made.

DMAS received numerous comments concerning the 30-day time period in which to develop the Individual Support Plan, including completion of the Supports Intensity Scale (SIS), and initiate services once the case manager has received confirmation of Medicaid eligibility and DBHDS' written confirmation of enrollment. This time limit derives from federal statute and the fact that DMAS uses the federally-permitted 300% of the Supplemental Security Income payment standard for one person. This waiver's coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the *Social Security Act* are considered as if they are institutionalized for the purpose of applying institutional deeming rules. All individuals under the waiver must meet the financial and non-

financial Medicaid eligibility criteria as well as the institutional level-of-care criteria. Because of this, such persons cannot go longer than 30 days without receiving services. DMAS is therefore constrained by federal law and regulation from changing this 30-day time limit to a longer period of time. Furthermore, since most of the participants in this waiver are already eligible for Medicaid, reducing the time period for the onset of services is not expected to affect but very few individuals.

Several commenters addressed the issue of the individual enrolled in the waiver giving consent and informed consent. The referenced proposed regulations section (§ 1010 (E)(1)(a) and (c)) implies the action of individual consent without actually employing this term. DMAS plans to further elaborate on this issue in the upcoming guidance document revisions in order to ensure that the individual enrolled in the waiver and his family members understand their options and are enabled to give informed consent.

On the issue of CSB/BHA staff being required to research patient pay amounts, DMAS offers this additional response. DMAS has established an electronic computerized system (called ARS/MEDICALL**)** by which this required research can be performed. This electronic system replaces the formerly used paper process. Even though this research must be conducted monthly (due to potential monthly changes in eligibility), it can be handled by clerical staff rather than the CSBs'/BHAs' professional staff. If DMAS were to separately reimburse for this research, the local CSBs/BHAs would have to create additional documentation to support their billings for the research time. Such additional billings and documentation would create additional audit requirements for which DMAS is not now funded nor staffed. Therefore, additional payments for this required research is neither funded nor logistically practical to implement.

All changes made in this regulatory action

Please list all changes that are being proposed and the consequences of the proposed changes. Describe new provisions and/or all changes to existing sections.

Almost all references to 'mental retardation' and 'MR' have been removed. The federal law was changed on this issue and DMAS is conforming its regulations accordingly. The only remaining use of this term is in the context of the name of an Intermediate Care Facility for the Mentally Retarded (ICF/MR). This is a federally defined institutional term, not affected by the referenced statute change, and is the institutional alternative for individuals enrolled in this waiver.

In conformance to the concept of person-centered planning, the use of the qualifier 'waiver' before 'individual' has been changed through-out the regulations to 'individual enrolled in the waiver'. The term ‘individual’ has been retained as the term for the person receiving waiver services as the regulations use the term ‘person’ to refer to providers’ employees.

Current section number	Proposed new section number, if	Current requirement	Proposed change and rationale

	applicable		
12 VAC 30-120-211 through 249		All MR/ID waiver's program requirements.	Suggested for repeal as they are outdated.
	12 VAC 30-120-1000		New definition section intended to replace previous § 211. Clarifying text is added indicating that case managers are employees of either CSBs or BHAs. A new definition for in-home residential support services has been added in response to public comments. Collaboration between case managers and services facilitators is provided for in response to public comments.
	12 VAC 30-120-1005		New section replaces current § 213. One general statement that the waiver's services are required in order to avoid institutionalization is added rather than multiple references throughout the regs in response to public comments.
	12 VAC 30-120-1010		New section replaces current § 215. Case managers are required to monitor on a monthly basis, rather than periodically, the new electronic system containing patient pay information so that required adjustments can be made. Establishment of a uniform assessment instrument (SIS form) to be used by all CSBs/ BHAs is provided to ensure greater uniformity statewide in the initial evaluation to determine what services the individual requires to remain in the community.
	12 VAC 30-120-1020		New section replaces parts of current §§ 221, 223, 225, 227, 229, 231, 233, 235, 237, 241, 245, 247 and 249. Covered services are essentially the same, including requiring prior authorization, as in the repealed sections with the exception of the addition of Services Facilitation. In the context of the last waiver application renewal with CMS, the federal reviewers required Services Facilitation to be treated as a free standing covered service in this waiver rather than an administrative benefit provided to all individuals enrolled in the waiver. CMS required that individuals have the opportunity to decline to receive Services Facilitation. Provision is also made for individuals to be involuntarily disenrolled from consumer directed services under specified circumstances. AT/EM services were restored to their current $5,000 annual limits. Calendar year tracking of these two services' expenditures must be retained as proposed, in spite of public comments to change back

			to the current individuals' plan years, for reasons of budget and program integrity. The proposed six-month increments for respite services has been removed so that the entire allowed hours (480) can be used at any time in a 12-month period in response to public comments. All services measured in blocks of time have been corrected to be hours and minutes rather than hours and seconds.
	12 VAC 30-120-1040		Replaces old § 219. Reference to the Fair Housing Amendments Act is added to the list of various statutes with which providers must comply in response to public comments.
	12 VAC 30-120-1060		Replaces parts of old §§ 221, 223, 225, 227, 229, 231, 233, 235, 237, 241, 245, 247 and 249. The minimum required elements for the Plan for Supports are specified. Reference is added that the individual enrolled in the waiver and the family/caregiver must agree to the Plan for Supports and all changes to it. Knowledge, skills, and abilities required for services facilitators (now located in 12 VAC 30-120-225) are retained rather than incorporating them by reference from a guidance document. Respite assistants' work records must contain references from two prior job experiences as is currently in effect.
	12 VAC 30-120-1070		Reimbursement limits are set out.
	12 VAC 30-120-1080		Replaces part of old § 213. Provides for performance of quality management reviews and provider audits. Providers determined to not be in compliance with these regulations may have their reimbursement retracted.
	12 VAC 30-120-1088		Replaces part of old § 213. During the referenced CMS' waiver application reauthorization process, CMS required the development of uniform statewide criteria for urgent and non-urgent waiting lists to be used in this waiver. There are not any substantial differences over the currently used policies.
	12 VAC 30-120-1090		Replaces part of old § 213. These provisions are the same as the current policies.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the

exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

Many of the providers who are governed by these regulations may be considered small businesses, including home health agencies, services facilitation providers, and durable medical equipment providers. Changes have been made where possible to facilitate a reduction of paperwork for those providers. These regulations do not exempt small businesses from all or any part of the regulations. However, the regulations provide some requirements for specific types of service providers and, in some cases, reduce the regulatory burden on these providers.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

This regulatory action will implement requirements for providers of MR/ID Waiver services. The standards provide the means for the agency to provide regulatory oversight in accordance with the law. It is also the basis for the accountability of services that are provided to a vulnerable population. This should have a positive impact on the stability of individuals and their family/caregivers receiving services from providers by promoting the quality of those services and an acceptable standard of care. The regulations encourage family involvement in services and should not have any negative impact on the authority of parents, self-sufficiency or individual responsibility, marital commitment, or family income. The MR/ID Waiver encourages self-pride and an assumption of responsibility for oneself, particularly when an individual elects the consumer-directed model of service delivery.