COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **MARY-GRACE MENDOZA** MM
Assistant Attorney General

DATE: **November 1, 2013**

SUBJECT: **Exempt Action - Waiver Skilled Nursing Services in Quarter Hour Increments (12 VAC 30-120-760; 12 VAC 30-120-1020)**

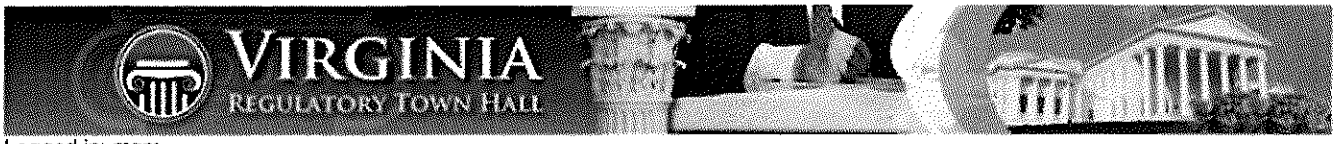
This memorandum responds to your request that this Office review the amendments to 12 VAC 30-120-760 and 12 VAC 30-120-1020, "Waiver Skilled Nursing Services in Quarter Hour Increments," which change the unit of service for skilled nursing services from one hour to 15-minute increments for the Intellectual Disability Waiver and the Family and Individuals with Developmental Disabilities Waiver.

Based on my review, it is this Office's view that DMAS has the authority, subject to compliance with the provisions of Article 2 of the Administrative Process Act (APA), and has not exceeded that authority.

The authority for this regulation is Chapter 806, Item 307 QQQQ of the 2013 Acts of the Assembly. Accordingly, it is my view that this action was properly promulgated as an exempt action pursuant to Va. Code § 2.2-4006.

Please call me at (804) 786-6004 if you have any questions regarding this memorandum. Thank you.

cc: Kim F. Piner
Chief/Senior Assistant Attorney General



Final Text

Action: Waiver Skilled Nursing Services in Quarter Hour Increments

Stage: Final 11/1/13 12:31 PM [latest]

12VAC30-120-760
12VAC30-120-760. Skilled nursing services.

A. Service description. Skilled nursing services shall be provided for individuals with serious medical conditions and complex health care needs who require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the home or other community setting. It may include consultation and training for other providers.

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

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in [~~hourly~~ 15-minute] units. Services must be explicitly detailed in the CSP and must be specifically ordered by a physician.

D. Provider requirements. Skilled nursing services shall be provided by a DMAS-enrolled home care organization provider or a home health provider, or licensed registered nurse or a licensed practical nurse under the supervision of a licensed registered nurse who is contracted or employed by a DMHMRSAS licensed day support, respite, or residential provider. In addition to meeting the general conditions and requirements for home and community-based waiver participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, in order to be enrolled as a skilled nursing provider, the provider must:

1. If a home health agency, be certified by the VDH for Medicaid participation and have a current DMAS provider participation agreement for private duty nursing;

2. Demonstrate a prior successful health care delivery business or practice;

3. Operate from a business office; and

4. If community services boards or behavioral health authority employ or subcontract with and directly supervise a registered nurse (RN) or a licensed practical nurse (LPN) with a current and valid license issued by the Virginia State Board of Nursing, the RN or LPN must have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, or nursing home.

12VAC30-120-1020
12VAC30-120-1020. Covered services; limits on covered services.

A. Covered services in the ID Waiver include: assistive technology, companion services (both consumer-directed and agency-directed), crisis stabilization, day support, environmental modifications, personal assistance services (both

consumer-directed and agency-directed), personal emergency response systems (PERS), prevocational services, residential support services, respite services (both consumer-directed and agency-directed), services facilitation (only for consumer-directed services), skilled nursing services, supported employment, therapeutic consultation, and transition services.

1. There shall be separate supporting documentation for each service and each shall be clearly differentiated in documentation and corresponding billing.

2. The need of each individual enrolled in the waiver for each service shall be clearly set out in the Individual Support Plan containing the providers' Plans for Supports.

3. Claims for payment that are not supported by their related documentation shall be subject to recovery by DMAS or its designated contractor as a result of utilization reviews or audits.

4. Individuals enrolled in the waiver may choose between the agency-directed model of service delivery or the consumer-directed model when DMAS makes this alternative model available for care. The only services provided in this waiver that permit the consumer-directed model of service delivery shall be: (i) personal assistance services; (ii) respite services; and (iii) companion services. An individual enrolled in the waiver shall not receive consumer-directed services if at least one of the following conditions exists:

(a) The individual enrolled in the waiver is younger than 18 years of age or is unable to be the employer of record and no one else can assume this role;

(b) The health, safety, or welfare of the individual enrolled in the waiver cannot be assured or a back-up emergency plan cannot be developed; or

(c) The individual enrolled in the waiver has medication or skilled nursing needs or medical/behavioral conditions that cannot be safely met via the consumer-directed model of service delivery.

5. Voluntary/involuntary disenrollment of consumer-directed services. Either voluntary or involuntary disenrollment of consumer-directed services may occur. In either voluntary or involuntary situations, the individual enrolled in the waiver shall be permitted to select an agency from which to receive his personal assistance, respite, or companion services.

a. An individual who has chosen consumer direction may choose, at any time, to change to the agency-directed services model as long as he continues to qualify for the specific services. The services facilitator or case manager, as appropriate, shall assist the individual with the change of services from consumer-directed to agency-directed.

b. The services facilitator or case manager, as appropriate, shall initiate involuntary disenrollment from consumer direction of the individual enrolled in the waiver when any of the following conditions occur:

(1) The health, safety, or welfare of the individual enrolled in the waiver is at risk;

(2) The individual or EOR, as appropriate, demonstrates consistent inability to hire and retain a personal assistant; or

(3) The individual or EOR, as appropriate, is consistently unable to manage the assistant, as may be demonstrated by, but shall not necessarily be limited to, a pattern of serious discrepancies with timesheets.

c. Prior to involuntary disenrollment, the services facilitator or case manager, as appropriate, shall:

(1) Verify that essential training has been provided to the individual or EOR, as appropriate, to improve the problem condition or conditions;

(2) Document in the individual's record the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator or case manager, as appropriate;

(3) Discuss with the individual or the EOR, as appropriate, the agency directed option that is available and the actions needed to arrange for such services while providing a list of potential providers; and

(4) Provide written notice to the individual and EOR, as appropriate, of the right to appeal, pursuant to 12VAC30-110, such involuntary termination of consumer direction. Such notice shall be given at least 10 business days prior to the effective date of this action.

d. If the services facilitator initiates the involuntary disenrollment from consumer direction, then he shall inform the case manager.

6. All requests for this waiver's services shall be submitted to either DMAS or the service authorization contractor for service (prior) authorization.

B. Assistive technology (AT). Service description. This service shall entail the provision of specialized medical equipment and supplies including those devices, controls, or appliances, specified in the Individual Support Plan but which are not available under the State Plan for Medical Assistance, that (i) enable individuals to increase their abilities to perform activities of daily living (ADLs); (ii) enable individuals to perceive, control, or communicate with the environment in which they live; or (iii) are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.

1. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. AT shall be covered in the least expensive, most cost-effective manner.

2. Service units and service limitations. AT shall be available to individuals who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. Only the AT services set out in the Plan for Supports shall be covered by DMAS. AT shall be prior authorized by the state-designated agency or its contractor for each calendar year with no carry-over across calendar years.

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

b. Costs for AT shall not be carried over from calendar year to calendar year and shall be prior authorized by the state-designated agency or its contractor each calendar year. AT shall not be approved for purposes of convenience of the caregiver or restraint of the individual.

3. An independent professional consultation shall be obtained from staff knowledgeable of that item for each AT request prior to approval by the state-designated agency or its contractor. Equipment, supplies, or technology not available as durable medical equipment through the State Plan may be purchased and billed as AT as long as the request for such equipment, supplies, or technology is documented and justified in the individual's Plan for Supports,

recommended by the case manager, prior authorized by the state-designated agency or its contractor, and provided in the least expensive, most cost-effective manner possible.

4. All AT items to be covered shall meet applicable standards of manufacture, design, and installation.

5. The AT provider shall obtain, install, and demonstrate, as necessary, such AT prior to submitting his claim to DMAS for reimbursement. The provider shall provide all warranties or guarantees from the AT's manufacturer to the individual and family/caregiver, as appropriate.

6. AT providers shall not be the spouse or parents of the individual enrolled in the waiver.

C. Companion (both consumer-directed and agency-directed) services. Service description. These services provide nonmedical care, socialization, or support to an adult (ages 18 or older). Companions may assist or support the individual enrolled in the waiver with such tasks as meal preparation, community access and activities, laundry, and shopping, but companions do not perform these activities as discrete services. Companions may also perform light housekeeping tasks (such as bed-making, dusting and vacuuming, laundry, grocery shopping, etc.) when such services are specified in the individual's Plan for Supports and essential to the individual's health and welfare in the context of providing nonmedical care, socialization, or support, as may be needed in order to maintain the individual's home environment in an orderly and clean manner. Companion services shall be provided in accordance with a therapeutic outcome in the Plan for Supports and shall not be purely recreational in nature. This service may be provided and reimbursed either through an agency-directed or a consumer-directed model.

1. In order to qualify for companion services, the individual enrolled in the waiver shall have demonstrated a need for assistance with IADLs, light housekeeping (such as cleaning the bathroom used by the individual, washing his dishes, preparing his meals, or washing his clothes), community access, reminders for medication self-administration, or support to assure safety. The provision of companion services shall not entail routine hands-on care.

2. Individuals choosing the consumer-directed option shall meet requirements for consumer direction as described herein.

3. Service units and service limitations.

a. The unit of service for companion services shall be one hour and the amount that may be included in the Plan for Supports shall not exceed eight hours per 24-hour day regardless of whether it is an agency-directed or consumer-directed service model, or both.

b. A companion shall not be permitted to provide nursing care procedures such as, but not limited to, ventilators, tube feedings, suctioning of airways, or wound care.

c. The hours that can be authorized shall be based on documented individual need. No more than two unrelated individuals who are receiving waiver services and who live in the same home shall be permitted to share the authorized work hours of the companion.

4. This consumer directed service shall be available to individuals enrolled in the waiver who receive congregate residential services. These services shall be available when individuals enrolled in the waiver are not receiving congregate residential services such as, but not necessarily limited to, when they are on vacation or are visiting with family members.

D. Crisis stabilization. Service description. These services shall involve direct interventions that provide temporary intensive services and support that avert emergency psychiatric hospitalization or institutional placement of individuals with ID who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services shall have two components: (i) intervention and (ii) supervision. Crisis stabilization services shall include, as appropriate, neuropsychiatric, psychiatric, psychological, and other assessments and stabilization techniques, medication management and monitoring, behavior assessment and positive behavioral support, and intensive service coordination with other agencies and providers. This service shall be designed to stabilize the individual and strengthen the current living situation, so that the individual remains in the community during and beyond the crisis period.

1. These services shall be provided to:

a. Assist with planning and delivery of services and supports to enable the individual to remain in the community;

b. Train family/caregivers and service providers in positive behavioral supports to maintain the individual in the community; and

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

2. In order to receive crisis stabilization services, the individual shall:

a. Meet at least one of the following: (i) the individual shall be experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) the individual shall be experiencing an increase in extreme emotional distress; (iii) the individual shall need continuous intervention to maintain stability; or (iv) the individual shall be causing harm to himself or others; and

b. Be at risk of at least one of the following: (i) psychiatric hospitalization; (ii) emergency ICF/ID placement; (iii) immediate threat of loss of a community service due to a severe situational reaction; or (iv) causing harm to self or others.

3. Service units and service limitations. Crisis stabilization services shall only be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional (QMRP).

a. The unit for either intervention or supervision of this covered service shall be one hour. This service shall only be authorized in 15-day increments but no more than 60 days in a calendar year shall be approved. The actual service units per episode shall be based on the documented clinical needs of the individual being served. Extension of services, beyond the 15-day limit per authorization, shall only be authorized following a documented face-to-face reassessment conducted by a QMRP.

b. Crisis stabilization services shall be provided directly in the following settings, but shall not be limited to:

(1) The home of an individual who lives with family, friends, or other primary caregiver or caregivers;

(2) The home of an individual who lives independently or semi-independently to augment any current services and supports; or

(3) Either a community-based residential program, a day program, or a respite care setting to augment ongoing current services and supports.

4. Crisis supervision shall be an optional component of crisis stabilization in which one-to-one supervision of the individual who is in crisis shall be provided by agency staff in order to ensure the safety of the individual and others in the

environment. Crisis supervision may be provided as a component of crisis stabilization only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided one-to-one and face-to-face with the individual. Crisis supervision, if provided as a part of this service, shall be separately billed in hourly service units.

5. Crisis stabilization services shall not be used for continuous long-term care. Room, board, and general supervision shall not be components of this service.

6. If appropriate, the assessment and any reassessments may be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.

E. Day support services. Service description. These services shall include skill-building, supports, and safety supports for the acquisition, retention, or improvement of self-help, socialization, community integration, and adaptive skills. These services shall be typically offered in a nonresidential setting that provides opportunities for peer interactions, community integration, and enhancement of social networks. There shall be two levels of this service: (i) intensive and (ii) regular.

1. Criteria. For day support services, individuals shall demonstrate the need for skill-building or supports offered primarily in settings other than the individual's own residence that allows him an opportunity for being a productive and contributing member of his community.

2. Types of day support. The amount and type of day support included in the individual's Plan for Supports shall be determined by what is required for that individual. There are two types of day support: center-based, which is provided primarily at one location/building; or noncenter-based, which is provided primarily in community settings. Both types of day support may be provided at either intensive or regular levels.

3. Levels of day support. There shall be two levels of day support, intensive and regular. To be authorized at the intensive level, the individual shall meet at least one of the following criteria: (i) the individual requires physical assistance to meet the basic personal care needs (such as but not limited to toileting, eating/feeding); (ii) the individual requires additional, ongoing support to fully participate in programming and to accomplish the individual's desired outcomes due to extensive disability-related difficulties; or (iii) the individual requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral support activities shall be required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation. Individuals not meeting these specified criteria for intensive day support shall be provided with regular day support.

4. Service units and service limitations.

a. This service shall be limited to 780 blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes. If this service is used in combination with prevocational, or group supported employment services, or both, the combined total units for day support, prevocational, or group supported employment services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.

b. Day support services shall be billed according to the DMAS fee schedule.

c. Day support shall not be regularly or temporarily provided in an individual's home setting or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from the state-designated agency or its contractor.

d. Noncenter-based day support services shall be separate and distinguishable from either residential support services or personal assistance services. The supporting documentation shall provide an estimate of the amount of day support required by the individual.

5. Service providers shall be reimbursed only for the amount and level of day support services included in the individual's approved Plan for Supports based on the setting, intensity, and duration of the service to be delivered.

F. Environmental modifications (EM). Service description. This service shall be defined, as set out in 12VAC30-120-1000, as those physical adaptations to the individual's primary home, primary vehicle, or work site that shall be required by the individual's Individual Support Plan, that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence. Environmental modifications reimbursed by DMAS may only be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act. Such adaptations may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual. Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services.

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

2. Service units and service limitations.

a. Environmental modifications shall be provided in the least expensive manner possible that will accomplish the modification required by the individual enrolled in the waiver and shall be completed within the calendar year consistent with the Plan of Supports' requirements.

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

EM shall be available to individuals enrolled in the waiver who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. EM shall be prior authorized by the state-designated agency or its contractor for each calendar year with no carry-over across calendar years.

c. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards.

d. Providers shall be reimbursed for their actual cost of material and labor and no additional mark-ups shall be permitted.

e. Providers of EM services shall not be the spouse or parents of the individual enrolled in the waiver.

f. Excluded from coverage under this waiver service shall be those adaptations or improvements to the home that are of general utility and that are not of direct medical or remedial benefit to the individual enrolled in the waiver, such as, but not necessarily limited to, carpeting, roof repairs, and central air conditioning. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act. Adaptations that add to the total square footage of the home shall be excluded from this service. Except when EM services are furnished in the individual's own home, such services shall not be provided to individuals who receive residential support services.

3. Modifications shall not be prior authorized or covered to adapt living arrangements that are owned or leased by providers of waiver services or those living arrangements that are sponsored by a DBHDS-licensed residential support provider. Specifically, provider-owned or leased settings where residential support services are furnished shall already be compliant with the Americans with Disabilities Act.

4. Modifications to a primary vehicle that shall be specifically excluded from this benefit shall be:

a. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;

b. Purchase or lease of a vehicle; and

c. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications that were covered under this waiver benefit.

G. Personal assistance services. Service description. These services may be provided either through an agency-directed or consumer-directed (CD) model.

1. Personal assistance shall be provided to individuals in the areas of activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. Such services, as set out in the Plan for Supports, may be provided and reimbursed in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with IADLs. Personal assistance shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service shall not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90 -20-420 through 18VAC90-20-460.

2. Criteria. In order to qualify for personal assistance, the individual shall demonstrate a need for assistance with ADLs, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

3. Service units and service limitations.

a. The unit of service shall be one hour.

b. Each individual, family, or caregiver shall have a back-up plan for the individual's needed supports in case the personal assistant does not report for work as expected or terminates employment without prior notice.

c. Personal assistance shall not be available to individuals who (i) receive congregate residential services or who live in assisted living facilities, (ii) would benefit from ADL or IADL skill development as identified by the case manager, or (iii) receive comparable services provided through another program or service.

d. The hours to be authorized shall be based on the individual's need. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the assistant.

H. Personal Emergency Response System (PERS). Service description. This service shall be a service that monitors individuals' safety in their homes, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individuals' home telephone system. PERS may also include medication monitoring devices.

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

2. Service units and service limitations.

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

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

c. PERS services shall not be used as a substitute for providing adequate supervision for the individual enrolled in the waiver.

I. Prevocational services. Service description. These services shall be intended to prepare an individual enrolled in the waiver for paid or unpaid employment but shall not be job-task oriented. Prevocational services shall be provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services. Activities included in this service shall not be directed at teaching specific job skills but at underlying habilitative outcomes such as accepting supervision, regular job attendance, task completion, problem solving, and safety. There shall be two levels of this covered service: (i) intensive and (ii) regular.

1. In order to qualify for prevocational services, the individual enrolled in the waiver shall have a demonstrated need for support in skills that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

2. Service units and service limitations. Billing shall be in accordance with the DMAS fee schedule.

a. This service shall be limited to 780 blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes. If this service is used in combination with day support or group-supported employment services, or both, the combined total units for prevocational services, day support and group supported employment services shall not exceed 780 blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes.

b. Prevocational services may be provided in center-based or noncenter-based settings. Center-based settings means services shall be provided primarily at one location or building and noncenter-based means services shall be provided primarily in community settings.

c. For prevocational services to be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) require physical assistance to meet the basic personal care needs (such as, but not limited to, toileting, eating/feeding); (ii) require additional, ongoing support to fully participate in services and to accomplish desired outcomes due to extensive disability-related difficulties; or (iii) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral support activities shall be required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation. Individuals not meeting these specified criteria for intensive prevocational services shall be provided with regular prevocational services.

3. There shall be documentation regarding whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for services through the IDEA due to his age, documentation shall be required only for lack of DRS funding. When these services are provided through these alternative funding sources, the Plan for Supports shall not authorize prevocational services as waiver expenditures.

4. Prevocational services shall only be provided when the individual's compensation for work performed is less than 50% of the minimum wage.

J. Residential support services. Service description. These services shall consist of skill-building, supports, and safety supports, provided primarily in an individual's home or in a licensed or approved residence, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Service providers shall be reimbursed only for the amount and type of residential support services that are included in the individual's approved Plan for Supports. There shall be two types of this service: congregate residential support and in-home supports. Residential support services shall be authorized for Medicaid reimbursement in the Plan for Supports only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider, or if these services exceed supports provided by the family/caregiver. Only in exceptional instances shall residential support services be routinely reimbursed up to a 24-hour period.

1. Criteria.

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

b. To qualify for this service in a congregate setting, the individual shall have a demonstrated need for continuous skill-building, supports, and safety supports for up to 24 hours per day.

c. Providers shall participate as requested in the completion of the DBHDS-approved SIS form or its approved substitute form.

d. The residential support Plan for Supports shall indicate the necessary amount and type of activities required by the individual, the schedule of residential support services, and the total number of projected hours per week of waiver reimbursed residential support.

e. In-home residential supports shall be supplemental to the primary care provided by the individual, his family member or members, and other caregivers. In-home residential supports shall not replace this primary care.

f. In-home residential supports shall be delivered on an individual basis, typically for less than a continuous 24-hour period. This service shall be delivered with a 1:1 staff-to-individual ratio except when skill building supports require interaction with another person.

2. Service units and service limitations. Total billing shall not exceed the amount authorized in the Plan for Supports. The provider must maintain documentation of the date and times that services have been provided, and specific circumstances that prevented provision of all of the scheduled services, should that occur.

a. This service shall be provided on an individual-specific basis according to the Plan for Supports and service setting requirements;

b. Congregate residential support shall not be provided to any individual enrolled in the waiver who receives personal assistance services under the ID Waiver or other residential services that provide a comparable level of care. Residential support services shall be permitted to be provided to the individual enrolled in the waiver in conjunction with respite services for unpaid caregivers;

c. Room, board, and general supervision shall not be components of this service;

d. This service shall not be used solely to provide routine or emergency respite care for the family/caregiver with whom the individual lives; and

e. Medicaid reimbursement shall be available only for residential support services provided when the individual is present and when an enrolled Medicaid provider is providing the services.

K. Respite services. Service description. These services may be provided either through an agency-directed or consumer-directed (CD) model.

1. Respite services shall be provided to individuals in the areas of activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, monitoring of self-administered medications or other medical needs, and monitoring of health status and physical condition in the absence of the primary caregiver or to relieve the primary caregiver from the duties of care-giving. Such services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with IADLs. Respite assistance shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service shall not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

2. Respite services shall be those that are normally provided by the individual's family or other unpaid primary caregiver. These covered services shall be furnished on a short-term, episodic, or periodic basis because of the absence of the unpaid caregiver or need for relief of the unpaid caregiver or caregivers who normally provide care for the individual.

3. Criteria.

a. In order to qualify for respite services, the individual shall demonstrate a need for assistance with ADLs, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

b. Respite services shall only be offered to individuals who have an unpaid primary caregiver or caregivers who require temporary relief. Such need for relief may be either episodic, intermittent, or periodic.

4. Service units and service limitations.

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

b. Each individual, family, or caregiver shall have a back-up plan for the individual's care in case the respite assistant does not report for work as expected or terminates employment without prior notice.

c. Respite services shall not be provided to relieve staff of either group homes, pursuant to 12VAC35-105-20, or assisted living facilities, pursuant to 22VAC40-72 -10, where residential supports are provided in shifts. Respite services shall not be provided for DMAS reimbursement by adult foster care providers for an individual residing in that foster home.

d. Skill development shall not be provided with respite services.

e. The hours to be authorized shall be based on the individual's need. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the respite assistant.

5. Consumer-directed and agency-directed respite services shall meet the same standards for service limits and authorizations.

L. Services facilitation and consumer-directed service model. Service description. Individuals enrolled in the waiver may be approved to select consumer directed (CD) models of service delivery, absent any of the specified conditions that precludes such a choice, and may also receive support from a services facilitator. Persons functioning as services facilitators shall be enrolled Medicaid providers. This shall be a separate waiver service to be used in conjunction with CD personal assistance, respite, or companion services and shall not be covered for an individual absent one of these consumer directed services.

1. Services facilitators shall train individuals enrolled in the waiver, family/caregiver, or EOR, as appropriate, to direct (such as select, hire, train, supervise, and authorize timesheets of) their own assistants who are rendering personal assistance, respite services, and companion services.

2. The services facilitator shall assess the individual's particular needs for a requested CD service, assisting in the development of the Plan for Supports, provide management training for the individual or the EOR, as appropriate, on his responsibilities as employer, and provide ongoing support of the CD model of

services. The service authorization for receipt of consumer directed services shall be based on the approved Plan for Supports.

3. The services facilitator shall make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the individual's needs, assist in the development of the Plan for Supports with the individual and the individual's family/caregiver, as appropriate, and provide employer management training to the individual and the family/caregiver, as appropriate, on his responsibilities as an employer, and providing ongoing support of the consumer-directed model of services. Individuals or EORs who are unable to receive employer management training at the time of the initial visit shall receive management training within seven days of the initial visit.

a. The initial comprehensive home visit shall be completed only once upon the individual's entry into the CD model of service regardless of the number or type of CD services that an individual requests.

b. If an individual changes services facilitators, the new services facilitator shall complete a reassessment visit in lieu of a comprehensive visit.

c. This employer management training shall be completed before the individual or EOR may hire an assistant who is to be reimbursed by DMAS.

4. After the initial visit, the services facilitator shall continue to monitor the individual's Plan for Supports quarterly (i.e., every 90 days) and more often as-needed. If CD respite services are provided, the services facilitator shall review the utilization of CD respite services either every six months or upon the use of 240 respite services hours, whichever comes first.

5. A face-to-face meeting shall occur between the services facilitator and the individual at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual. During these visits with the individual, the services facilitator shall observe, evaluate, and consult with the individual, EOR, and the individual's family/caregiver, as appropriate, for the purpose of documenting the adequacy and appropriateness of CD services with regard to the individual's current functioning and cognitive status, medical needs, and social needs. The services facilitator's written summary of the visit shall include, but shall not necessarily be limited to:

a. Discussion with the individual and EOR or family/caregiver, as appropriate, whether the particular consumer directed service is adequate to meet the individual's needs;

b. Any suspected abuse, neglect, or exploitation and to whom it was reported;

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

d. Individual's and EOR's or family/caregiver's, as appropriate, satisfaction with the assistant's service;

e. Any hospitalization or change in medical condition, functioning, or cognitive status;

f. The presence or absence of the assistant in the home during the services facilitator's visit; and

g. Any other services received and the amount.

6. The services facilitator, during routine visits, shall also review and verify timesheets as needed to ensure that the number of hours approved in the Plan for Supports is not exceeded. If discrepancies are identified, the services facilitator

shall discuss these with the individual or the EOR to resolve discrepancies and shall notify the fiscal/employer agent. If an individual is consistently identified as having discrepancies in his timesheets, the services facilitator shall contact the case manager to resolve the situation.

7. The services facilitator shall maintain a record of each individual containing elements as set out in 12VAC30-120-1060.

8. The services facilitator shall be available during standard business hours to the individual or EOR by telephone.

9. If a services facilitator is not selected by the individual, the individual or the family/caregiver serving as the EOR shall perform all of the duties and meet all of the requirements, including documentation requirements, identified for services facilitation. However, the individual or family/caregiver shall not be reimbursed by DMAS for performing these duties or meeting these requirements.

10. If an individual enrolled in consumer-directed services has a lapse in services facilitator duties for more than 90 consecutive days, and the individual or family/caregiver is not willing or able to assume the service facilitation duties, then the case manager shall notify DMAS or its designated prior authorization contractor and the consumer-directed services shall be discontinued once the required 10 days notice of this change has been observed. The individual whose consumer-directed services have been discontinued shall have the right to appeal this discontinuation action pursuant to 12VAC30-110. The individual shall be given his choice of an agency for the alternative personal care, respite, or companion services that he was previously obtaining through consumer direction.

11. The CD services facilitator, who is to be reimbursed by DMAS, shall not be the individual enrolled in the waiver, the individual's case manager, a direct service provider, the individual's spouse, a parent of the individual who is a minor child, or the EOR who is employing the assistant/companion.

12. The services facilitator shall document what constitutes the individual's back-up plan in case the assistant/companion does not report for work as expected or terminates employment without prior notice.

13. Should the assistant/companion not report for work or terminate his employment without notice, then the services facilitator shall, upon the individual's or EOR's request, provide management training to ensure that the individual or the EOR is able to recruit and employ a new assistant /companion.

14. The limits and requirements for individuals' selection of consumer directed services shall be as follows:

a. In order to be approved to use the CD model of services, the individual enrolled in the waiver, or if the individual is unable, the designated EOR, shall have the capability to hire, train, and fire his own assistants and supervise the assistants' performance. Case managers shall document in the Individual Support Plan the individual's choice for the CD model and whether or not the individual chooses services facilitation. The case manager shall document in this individual's record that the individual can serve as the EOR or if there is a need for another person to serve as the EOR on behalf of the individual.

b. An individual enrolled in the waiver who is younger than 18 years of age shall be required to have an adult responsible for functioning in the capacity of an EOR.

c. Specific employer duties shall include checking references of assistants, determining that assistants meet specified qualifications, timely and accurate completion of hiring packets, training the assistants, supervising assistants'

performance, and submitting complete and accurate timesheets to the fiscal/employer agent on a consistent and timely basis.

M. Skilled nursing services. Service description. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled nursing services may be provided in the individual's home or other community setting on a regularly scheduled or intermittent basis. It may include consultation, nurse delegation as appropriate, oversight of direct support staff as appropriate, and training for other providers.

1. In order to qualify for these services, the individual enrolled in the waiver shall have demonstrated complex health care needs that require specific skilled nursing services as ordered by a physician that cannot be otherwise provided under the Title XIX State Plan for Medical Assistance, such as under the home health care benefit.

2. Service units and service limitations. Skilled nursing services shall be rendered by a registered nurse or licensed practical nurse as defined in 12VAC30-120-1000 and shall be provided in [~~hourly~~ 15-minute] units in accordance with the DMAS fee schedule as set out in DMAS guidance documents. The services shall be explicitly detailed in a Plan for Supports and shall be specifically ordered by a physician as medically necessary.

N. Supported employment services. Service description. These services shall consist of ongoing supports that enable individuals to be employed in an integrated work setting and may include assisting the individual to locate a job or develop a job on behalf of the individual, as well as activities needed to sustain paid work by the individual including skill-building supports and safety supports on a job site. These services shall be provided in work settings where persons without disabilities are employed. Supported employment services shall be especially designed for individuals with developmental disabilities, including individuals with ID, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential (i.e., the individual's ability to perform work).

1. Supported employment services shall be available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disabilities need ongoing support to perform in a work setting. The individual's assessment and Individual Support Plan must clearly reflect the individual's need for employment-related skill building.

2. Supported employment shall be provided in one of two models: individual or group.

a. Individual supported employment shall be defined as support, usually provided one-on-one by a job coach to an individual in a supported employment position. For this service, reimbursement of supported employment shall be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the individual enrolled in the waiver is in the supported employment situation.

b. Group supported employment shall be defined as continuous support provided by staff to eight or fewer individuals with disabilities who work in an enclave, work crew, bench work, or in an entrepreneurial model.

3. Criteria.

a. Only job development tasks that specifically pertain to the individual shall be allowable activities under the ID Waiver supported employment service and DMAS

shall cover this service only after determining that this service is not available from DRS for this individual enrolled in the waiver.

b. In order to qualify for these services, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports and, that because of his disability, he needs ongoing support to perform in a work setting.

c. Providers shall participate as requested in the completion of the DBHDS-approved assessment.

d. The Plan for Supports shall document the amount of supported employment required by the individual.

4. Service units and service limitations.

a. Service providers shall be reimbursed only for the amount and type of supported employment included in the individual's Plan for Supports, which must be based on the intensity and duration of the service delivered.

b. The unit of service for individual job placement supported employment shall be one hour. This service shall be limited to 40 hours per week per individual.

c. Group models of supported employment shall be billed according to the DMAS fee schedule.

d. Group supported employment shall be limited to 780 blocks per individual, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes. If this service is used in combination with prevocational and day support services, the combined total unit blocks for these three services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.

O. Therapeutic consultation. Service description. This service shall provide expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual enrolled in the waiver. The specialty areas shall be (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services shall be based on the individuals' Individual Support Plans, and shall be provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their abilities to function in the community. Therapeutic consultation services may be provided in individuals' homes, and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to facilitate implementation of individuals' desired outcomes as identified in their Individual Support Plans.

1. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the Individual Support Plan cannot be implemented effectively and efficiently without such consultation as provided by this covered service.

a. The individual's therapeutic consultation Plan for Supports shall clearly reflect the individual's needs, as documented in the assessment information, for specialized consultation provided to family/caregivers and providers in order to effectively implement the Plan for Supports.

b. Therapeutic consultation services shall not include direct therapy provided to individuals enrolled in the waiver and shall not duplicate the activities of other

services that are available to the individual through the State Plan for Medical Assistance.

2. The unit of service shall be one hour. The services must be explicitly detailed in the Plan for Supports. Travel time, written preparation, and telephone communication shall be considered as in-kind expenses within this service and shall not be reimbursed as separate items. Therapeutic consultation shall not be billed solely for purposes of monitoring the individual.

3. Only behavioral consultation in this therapeutic consultation service may be offered in the absence of any other waiver service when the consultation is determined to be necessary.

P. Transition services. Transition services, as defined at and controlled by 12VAC30-120-2000 and 12VAC30-120-2010, provide for set-up expenses for qualifying applicants. The ID case manager shall coordinate with the discharge planner to ensure that ID Waiver eligibility criteria shall be met. Transition services shall be prior authorized by DMAS or its designated agent in order for reimbursement to occur.