Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Virginia** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Community Living Waiver

C. Waiver Number:VA.0372
Original Base Waiver Number: VA.0372.

D. Amendment Number:

E. Proposed Effective Date: *(mm/dd/yy)*

01/01/27

Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to make changes in accordance with budget items passed by the General Assembly in the 2026 Appropriations Act. Additionally, administrative updates are being made to reflect current practices and operations.
1. Implementing a 56-hour limit on personal care/assistance to mirror the 56-hour soft cap limit in the CCC+ Waiver. The cost projections for WY4 and WY5 are updated as a result. (Item 291.MMMMM)
2. Incorporating services facilitation into the statewide service broker model via the Fiscal-Employer Agent contract and eliminate services facilitation as a standalone service. Due to the proposed plan to transition those using consumer-directed services to support brokers, a subsequent amendment will be submitted to remove Services Facilitation from the waiver once all individuals are covered through support brokers. (Item 295.PP)
3. Modify program rules for consumer-directed services to allow an individual receiving services to serve as the Employer of Record (EOR) for his own service delivery and designate another individual to perform all or a portion of the duties of the EOR on the individual's behalf when the individual receiving services is unable to perform such duties or direct his own care. In seeking federal authority to modify such rules, DMAS shall ensure that the employer identification number (EIN) shall be assigned to the individual receiving services and shall not be transferred to another individual except when an individual: (i) has not yet reached the age of majority; (ii) is ineligible to use his existing EIN to facilitate the taxation of benefits; or (iii) is otherwise determined to be ineligible by DMAS by administrative rule (Item 295.ZZ)
4. Removing the Eligibility Group "Working Individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)." This checkbox was checked in error and has not been operationalized
5. Removing "Legally Responsible Person" from Employment and Community Transportation as allowable providers of the service. This checkbox was checked in error and has not been operationalized
6. Correcting requirements for when a legally responsible individual is a paid caregiver and the individual uses the consumer-directed model. The prior language references a wrong form and an "enhanced enrollment agreement" that has been incorporated into the standard enrollment packet by the fiscal-employer agents

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☑ **Appendix A - Waiver Administration and Operation**	A3
☑ **Appendix B - Participant Access and Eligibility**	B4
☑ **Appendix C - Participant Services**	C1/C3, C2
☐ **Appendix D - Participant Centered Service Planning and Delivery**	
☑ **Appendix E - Participant Direction of Services**	E1
☐ **Appendix F - Participant Rights**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☑ Appendix J - Cost-Neutrality Demonstration	J2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☑ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:

1. Updating requirements for legally responsible individuals who are paid caregivers when the consumer-directed model is used
2. Incorporating services facilitation into the statewide service broker model via the Fiscal-Employer Agent contract and eliminate services facilitation as a standalone service. Due to the transition to phase in support brokers and to phase out Services Facilitation, references to Services Facilitation throughout the application are updated to "Services Facilitator/Services Facilitation (until 5/31/27) and/or Support Broker (starting 3/1/27)".
3. Modify program rules for consumer-directed services to allow an individual receiving services to serve as the Employer of Record (EOR) for his own service delivery and designate another individual to perform all or a portion of the duties of the EOR on the individual's behalf when the individual receiving services is unable to perform such duties or direct his own care

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Virginia** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Community Living Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ● **5 years**

Original Base Waiver Number: VA.0372

Draft ID: **VA.008.05.03**

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/24
Approved Effective Date of Waiver being Amended: 07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

- **Hospital as defined in 42 CFR § 440.10**
  If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:
- **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

- **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**
  If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:
- **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Not applicable.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under section 1915(b) of the Act.**

  Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

  Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

  - ☐ **section 1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **section 1915(b)(2) (central broker)**
  - ☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **section 1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under section 1932(a) of the Act.**

  Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:
- ☐ **A program authorized under section 1915(i) of the Act.**
- ☐ **A program authorized under section 1915(j) of the Act.**
- ☐ **A program authorized under section 1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- ☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Community Living waiver, is a Home and Community-Based 1915(c) waiver designed to provide support in the community for individuals with intellectual and developmental disabilities in lieu of an Intermediate Care Facility for Individuals with Intellectual Disabilities.

The goals of the Community Living Waiver are to facilitate the transition of individuals currently residing in the institutions to life in the community and to enable those community residents in need of supports to retain their community resident status through receiving those supports.

The objectives of the Community Living Waiver are to:

1) Promote independence for individuals through high quality services and the assurance of health, safety, and welfare through a comprehensive quality management strategy;
2) Offer an alternative to institutionalization and costly comprehensive services through an array of community supports that promotes inclusion and independence by enhancing, rather than replacing, existing natural supports;
3) Support individuals and their families in sharing responsibility for their supports and services.

The daily operation of the Community Living Waiver is carried out by the Department of Behavioral Health and Developmental Services (DBHDS), the operating agency, under the supervision and authority of the Department of Medical Assistance Services (DMAS), the Medicaid agency. DMAS exercises administrative discretion in the administration and supervision of the waiver; issues policies, rules and regulations related to the waiver; and makes payment for waiver services provided through the Virginia Medicaid Management Information System (VAMMIS). An interagency agreement, on file at both agencies, ensures accountability and effective management for all waiver requirements and assurances. It is reviewed annually and updated when needed.

Individuals access services at the local level via the Community Services Board (CSB) system, as the single point of entry. There are forty CSBs throughout Virginia, with each city or county belonging to the catchment area of one CSB.

The Community Living Waiver offers qualifying individuals the opportunity to obtain either agency-directed services or consumer-directed services, or both. Individuals may be supported by a CSB-employed or private support coordinator (case manager) contracted with a CSB.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and

welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

A single public comment period for the proposed amendments for all four 1915(c) waivers was made available from August 6, 2024 to September 6, 2024. Tribes in Virginia were also notified of these renewals on September 6, 2024, with a request for any comments. The following tribes were notified: Pamunkey Indian Tribe, Chickahominy Indian Tribe, Monacan Indian Nation Inc., Nansemond Indian Tribe, Rappahannock Tribe, Eastern Chickahominy, and Upper Mattaponi Tribe. No comments were received.
DMAS provided notice of public comment through an online notification posted to the agency's website for thirty days. The waiver application with amendments was also available for public viewing on the DMAS agency website, along with instructions for submitting questions and/or comments via the Virginia Town Hall website, email, fax, and mail.
DMAS also solicited public comment in the Richmond Times-Dispatch, both the print edition and online through the newspaper's website and through the Public Notice Virginia website via the Virginia Press Association. The notice was published in the newspaper on Tuesday, August 20, 2024. Instructions were provided both print and online on the methods to submit questions and comments, as well as direct links to the waiver applications available on the DMAS website.
DMAS notified the Virginia DD Waiver Advisory Council (DDWAC) of the public comment period via official email on August 6, 2024. DBHDS also sent out official notification to listserv (DD Waiver Provider Community) of public comment on August 6, 2024.
DMAS received a total of 240 comments during the public comment period that addressed one or more of the respective waivers on a variety of topics. The comments were able to be broken down into categories, and the following comments applied to the Community Living Waiver:

1. Comment: 108 commenters stated that parents/LRI should be the first-or, in some comments, the only option when it comes to providing care for an individual with disabilities or disagreed with a particular portion of the LRI rules being put in place, whether citing the need to complete paperwork, complaining about the "administrative burden," to provide objective written documentation through the Extraordinary Care Form that was used when the state was required by legislation to prove "no one else was available to provide the care." Commenters complained that demonstrating extraordinary care needs shouldn't be required, or that there should be no rules or guardrails in place when it comes to LRIs providing care. One commenter said that there should be no difference in a parent's role as a parent and as an aide/attendant.
DMAS Response: DMAS thanks these individuals for their comments. DMAS is required by CMS to define extraordinary care and how it is determined as part of the waiver application. The State is not requiring LRIs to demonstrate objective, written documentation to demonstrate that no one else is available to provide care. DMAS does not interfere with normal unpaid parenting responsibilities; however, as a provider of Medicaid services, the LRI must abide by Medicaid rules.
2. Comment: 7 commenters stated that LRIs should get respite because parents still deserve to take a break, and CD attendants receive no benefits.
DMAS Response: Under the current definition of respite, the primary caregiver must be unpaid in order to receive the service. No changes will be made. Further, CD attendants who work an average of 30 hours per week are eligible for the paid leave benefit.
3. Comment: 34 commenters expressed general support for the LRI provisions.
DMAS Response: Thank you for your comment.
4. Comment: 25 commenters expressed general opposition to the amendment changes. Most cited changes to LRI provisions in that they wanted none of the rules in place. An additional eight commenters stated that there should be no changes to LRI rules.
DMAS Response: Thank you for your comment.
5. Comment: 17 commenters expressed opposition to the removal of education requirements for services facilitators, while 13 commenters supported the change. One commenter said that the state should come up with a certification process or training program similar to that of real estate agents. Many stated that services facilitators are already derelict in their responsibilities or do not know how to perform their jobs properly. Personal care agency supporters stated it creates an inequity in the system by having educational requirements for personal care agency staff, but anyone can be a services facilitator, making the system unbalanced. Those in favor of the change stated that a college degree does not mean a person has compassion for the job; others stated that this would alleviate the backlog of work that one Services Facilitator agency has.
DMAS Response: DMAS is disheartened by the statements that services facilitators have a backlog of work that has resulted in service authorizations not being submitted, leading to interruptions in services. DMAS has stressed through provider guidance and manuals that if a provider cannot adequately staff a case, they should assist the individual/family with locating an alternative. It would appear that this provider has not done this to the detriment of families across the Commonwealth. Furthermore, currently, services facilitators are required to complete provider training every five years

and complete an assessment scoring at least 80%.
This item was approved by the General Assembly through a budget amendment. DMAS must comply with the mandate.
Continued Main B. Optional

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Bevan

First Name: Ann

Title: Director, Division of Developmental Disabilities and Behavioral Health

Agency: Virginia Department of Medical Assistance Services

Address: 600 East Broad Street

Address 2:

City: Richmond

State: **Virginia**

Zip: 23219

Phone: (804) 588-4887 **Ext:** ☐ **TTY**

Fax: (804) 452-5468

E-mail: ann.bevan@dmas.virginia.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: DeStefano

First Name: Nicole

Title: Director, Waiver Operations

Agency: Department of Behavioral Health and Developmental Services

Address: 1220 Bank Street

Address 2:

City: Richmond

State: **Virginia**

Zip: 23219

Phone: (804) 971-6383 **Ext:** ☐ **TTY**

Fax: (804) 692-0077

E-mail: nicole.destefano@dbhds.virginia.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Virginia

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☑ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☑ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

1/1/27 Transition Plans:

1. Implementing a 56-hour limit on personal care/assistance to mirror the 56-hour soft cap limit in the CCC+ Waiver. The cost projections for WY4 and WY5 are updated as a result. (Item 291.MMMMM)

Upon CMS approval, the Commonwealth will implement a soft cap of 56 hours per week for personal assistance via its Community Living and Family/Individual Supports Waivers. This implementation will be staged across a communication & education phase; review of exception requests phase; final application of requirements (excluding those meeting the exceptional criteria); and ongoing monitoring.

PHASE 1 - Communication & Education

In advance of final approval, the Commonwealth will begin communication and education with the community regarding the potential implications of the 56 hour implementation. This will include communication and education with the local community services boards (case management entities); key community and advocacy organizations; and individual stakeholders. Education

will include information on alternative services available within the CL and FIS waivers that may better address individual support needs; the tentative process of requesting exceptions to the 56 hour soft cap; and education on how to file an appeal where applicable. Target dates for communication and education shall fall between October 1, 2026 and December 31, 2026.

PHASE 2 - Review of Exceptional Criteria

Upon final approval, the Commonwealth shall encourage the submission of service authorization requests with documentation supporting an exception to the 56 hour soft-cap. These service authorizations shall be submitted to the state's operational vendor [Department of Behavioral Health and Developmental Services] and reviewed on an individual basis. Requests that are approved shall be approved consistent with all appropriate regulatory requirements. Requests that are denied and/or modified shall result in the issuance of appropriate appeal rights. Target dates for review of exceptional criteria shall run for approximately 60 to 90 days based upon number of authorizations submitted for review.

PHASE 3 - Final Application

Following the completion of Phase 2, the Commonwealth shall begin applying the 56 hour soft cap to all existing service authorization across the Community Living and Family/Individual Supports Waivers. Any existing active authorization for personal assistance shall be automatically adjusted to 56 hours [provided it was previously authorized for 57 hours or more weekly]. The Department of Medical Assistance Services shall collaborate with the local community services boards to ensure the appropriate appeal rights are issued in conjunction with this action. Target dates for final implementation shall occur at the close of the exceptional review phase.

PHASE 4 - Ongoing Monitoring

The application of a 56 hour soft cap shall be fully integrated into the individual planning and authorization process for personal assistance within the Community Living and Family/Individual Supports Waivers. A request for exception may be submitted at any time by the individual and his planning team for review by the service authorization vendor.

2. Incorporating services facilitation into the statewide service broker model via the Fiscal-Employer Agent contract and eliminate services facilitation as a standalone service. Due to the proposed plan to transition those using consumer-directed services to support brokers, a subsequent amendment will be submitted to remove Services Facilitation from the waiver once all individuals are covered through support brokers. (Item 295.PP)

All individuals in consumer direction are required to use a Services Facilitator in order to provide information and training for perspective employers in the CD model. The SFs also perform assessments in developing Plans of Care for CD personal care, respite, and/or companion (dependent on waiver). As a result of the legislative change, the State will contract with its Fiscal Employer Agent (F/EA) to provide support broker services in lieu of Services Facilitation as a distinct waiver service. The State

is engaging in a phased-in approach to initiate the rollout of support brokers in order to ensure a smooth transition from Services Facilitation.

Individuals in consumer direction will be given communications as applicable from DMAS, the managed care organizations, DBHDS, community services boards, and fiscal-employer agents (F/EA) (as appropriate) regarding the transition away from

services facilitation and to support brokers. This communication will include language that individuals will not lose their current

CD attendant, no new F/EA enrollment paperwork will need to be completed, and that the individual's current service authorization as developed by the Services Facilitator (excepting any break in eligibility or need for reassessment) with an additional 90 days added to ensure time for a support broker to perform a face-to-face visit. These communications will begin 1/1/27 and throughout the transition process.

Support Broker services will be rolled out regionally to ensure a smooth transition. There will be 5 regions and they will transition in the
following order:
March 1, 2027: Regions 1 (Western) and 3 (Southwestern)
April 1, 2027: Region 4 (Central)
May 1, 2027: Region 5 (Tidewater)
June 1, 2027: Region 2 (Northern) and Tangier Island

At the beginning of each regional rollout, impacted members will be identified and the current authorizations from the SF provider will be ended and a new authorization through the support broker will be created and extended for 90 days of the previous end date to ensure continuity of care. This will provide time for scheduling of the support broker's face-to-face visit and

to prevent any lapse in services. In order for support brokers to be aware of the individual's needs, supports, and to understand the current service authorization, DMAS, DBHDS, and the MCOs shall share information and documentation on each individual's most recent assessment, service plan, and plan of care developed by the Services Facilitator. During the rollout, support brokers will contact the individual to conduct a visit within 90 days of the individual's region coming under support brokerage. If an individual is new to consumer direction and lives in a region covered through support brokers, the the community services board support coordinator must contact the Fiscal-Employer Agent's support brokers to initiate consumer directed services, and the Fiscal-Employer Agent shall perform an initial face-to-face visit with the individual and Employer of Record within ten (10) days of receiving the request.

Enrolled Services Facilitation providers will be expected to continue to provide services to members until they are transitioned to

support brokers. This applies to both their existing clientele and any individuals new to consumer-direction. If an individual within a region covered by support brokerage contacts a Services Facilitator, the Services Facilitator shall refer the individual to the Fiscal-Employer Agent for support brokers.

The State will transition the end of Services Facilitation through the following actions:
On January 1, 2027, DMAS shall cease to accept new Services Facilitation provider enrollments.

Between January 1, 2027 through May 31, 2027, DMAS will monitor enrolled Services Facilitation providers who may choose to cease operations prior to May 31, 2027. Care managers/Support Coordinators will assist individuals to locate a replacement Services Facilitator until the individual's region is incorporated into the support broker model. DMAS shall work with DBHDS, the MCOs, and remaining Services Facilitators to transfer services to prevent any disruption in services. Services Facilitators who cease operations prior to May 31, 2027 are still required, per Virginia regulations, to provide advance notice to members of their discharge from their services and to assist individuals with locating a replacement Services Facilitator.

DMAS shall release ongoing communications via bulletin, email, and training to Services Facilitation providers on the timeline for the sunset of Services Facilitation with a particular focus regarding their requirements to maintain provider records for the purposes of state and federal post-payment reviews, quality management reviews, and audits. Such communication will include that failure to adhere to such requirements may result in retraction of Medicaid payments and/or legal action.

3. Removing the Eligibility Group "Working Individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)."

This eligibility group has been checked in error. The State has not operationalized this eligibility group for enrollment in this waiver as the State offers this eligibility group a similar service as that found in the waiver at a higher income and resource threshold. Procedurally in current practice, this eligibility group and this waiver are mutually exclusive. Individuals who are currently enrolled in this aid category are not eligible to enroll in the waiver as they have available services already through their eligibility group, and likewise, as individuals on this waiver choose to transition to this eligibility group, they are removed from

the waiver due to the similar services available as part of the eligibility group. If an individual no longer qualifies under this eligibility group, they are re-evaluated as necessary for other Medicaid eligibility groups and may at that point seek enrollment in

this waiver via the same assessment process as outlined in this application. Further, the State affords individuals on this waiver who transition to this eligibility group a period of 180 days where they can, at any time during that period, return to this waiver with no waiting. Therefore, there is no need to develop procedures or a transition plan to move individuals on this waiver in this eligibility group.

5. Removing "Legally Responsible Person" from Employment and Community Transportation as allowable providers of the service.
This checkbox was checked in error. The State has not operationalized legally responsible persons as providers of this service. Persons with a legal responsibility to another are expected to provide transportation for community events and employment as part of their normal responsibilities. Individuals who access this service are able to select from various providers enrolled within

Virginia Medicaid to provide transportation. Therefore, there is no need to develop procedures or a transition plan to move individuals on this waiver to other providers of this service.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

6. Comment: 17 commenters argued that the effective date of the amendment should be March 1, 2024. Some argued that they were taking care of their children and should be compensated back pay for it.
DMAS Response: As these items are substantive in nature, we cannot request a retroactive date. DMAS shared the timeline during the General Assembly with legislators and that no actions could go into effect until the amendment process was undertaken and approved by CMS.
7. Comment: 11 commenters expressed a desire to eliminate objective written documentation for live-in aides and attendants who are not LRI.
DMAS Response: We disagree. Objective, written documentation has been a mainstay when a relative is a paid caregiver to ensure that the services being delivered are in the individual's best interest.
8. Comment: 6 commenters expressed general dissatisfaction with various items, such as Home and Community-Based Services, case management/waiver oversight as a whole, Medicaid in Virginia, or the Virginia minimum wage.
DMAS Response: Thank you for your comments. Individuals are encouraged to speak with their case manager or providers if they are dissatisfied with their Medicaid services, including waiver services. Individuals are welcome to express their dissatisfaction and to change providers if they so choose. The State is required to provide oversight for all 1915(c) waivers to meet the CMS assurances.
9. Comment: 6 commenters expressed general support for the changes in the amendments.
DMAS Response: Thank you for your comments.

10. Comment: 4 commenters asked that the state support allowing non-LRI relatives to be the paid aide/attendant.
DMAS Response: DMAS has already allowed non-LRI relatives, including parents of adult children, to be the paid aide/attendant for years. No changes are being made for these relatives.

11. Comment: 3 commenters said rates should be increased for a variety of different services, including some services not in any of the waivers. An additional 2 commenters stated that the rates should be raised for LRI.
DMAS Response: The General Assembly mandates any rate increases. DMAS does not agree that only one portion of the personal care workforce should receive a rate increase while others do not. Rate increases for personal care should be across the board regardless of the employee's relationship to the individual.
12. Comment: 2 commenters stated parents of adult children should get respite.
DMAS Response: No changes to rules for respite when the individual is an adult are being made. Respite requires an unpaid primary caregiver. If the parent of the adult child is the primary caregiver and is being paid to provide a Medicaid service, respite is not a compatible service. Respite is available if the primary caregiver is unpaid.
13. Comment: 2 commenters said that LRI should get paid for more than 40 hours or for all the hours they provide care to their children.
DMAS Response: The reimbursement of 40 hours per week is consistent with a typical work week. The individual will be approved for the amount of services needed. The LRI can be reimbursed for up to 40 hours per week. An additional paid caregiver may deliver the remaining hours on the individual's service plan.
14. Comment: 1 commenter said that all services facilitation visits should be virtual.
DMAS Response: We disagree. As shared by other commenters, there have been complaints that Services Facilitators have failed to do their jobs currently. Further, we believe that face-to-face visits are the best, and most often the only way to fully evaluate an individual's health condition and environmental surroundings in developing the provider Plan of Care. A virtual visit limits a professional only to what can be seen on the screen.
15. Comment: 1 commenter expressed that oversight of providers is not needed, particularly in consumer direction.
DMAS Response: We disagree. The state's responsibility is to oversee the services provided through Medicaid. In consumer-directed services, oversight is paramount to making sure the individual receives appropriate services and to ensure their health and safety. A
16. Comment: 1 commenter expressed that Services Facilitation visits should be quarterly as a way to reduce the backlog of work that their services facilitator has with the monthly visits.
DMAS Response: Services facilitation visits are currently required at least quarterly. DMAS has reminded providers that the standard frequency of the visits should be quarterly, and only in cases where it is documented that it is necessary to visit monthly and where the individual/family has agreed upon it should it be more frequent. Any provider that requires visits more than quarterly as a standard practice is not abiding by waiver rules.
17. Comment: One commenter expressed gratitude for the waivers and HCBS.
DMAS Response: Thank you for your comment.

18. Comment: 21 commenters expressed support for the combining of the annual service limits for AT and EHBS, though some argued that EM should have been included.
DMAS Response: Thank you for your comment. DMAS did not oppose the inclusion of EM in the combining of caps; however, we asked that the CCC Plus Waiver be included as well. When the advocates who devised the bill were approached with this information, they withdrew the inclusion of EM in the bill.

19. Comment: 16 commenters expressed support for not counting SSDI income as part of an individual's pre-eligibility treatment of income.
DMAS Response: DMAS thanks you for your comment.
20. Comment: 13 commenters expressed support for allowing DD waiver individuals to hold onto a slot for up to one year after being allocated a slot. These commenters stated that it sometimes takes a long time for people to line up providers.
DMAS Response: DMAS thanks you for your comment.

21. Comment: 12 commenters had questions about or requested changes to the language in the applications or to align similar language across multiple applications.
DMAS Response: Thank you for your comments. DMAS has made changes to the following:
-Aligning language in Appendix A in that DMAS releases the rates and has final say in rates paid to providers;
- Aligning language in Group Home in C1/C3 regarding telehealth
- Following questions on the definition of the EOR in multiple places if the individual is under the age of 18 or is not able to handle the role, we have added "designated adult";
- Aligning language in Services Facilitation service limits regarding telehealth and routine/reassessment visits that was unclear in the FIS waiver by transferring language from the CL waiver and clarifying the timeframes for routine visits and reassessment visits;
- Aligning language for Shared Living for BI and FIS by replacing "live-in companion" with "roommate" as well as who can provide shared living;
-Clarifying Services Facilitation educational requirements to mean successful passing grades in the Services Facilitation modules at least every 5 years;
Changes that were not made include:
(1): Requests to change references to "providers", "attendant", "provider organization", or to define them
22. Comment: Two commenters stated that the CSB quarterly reports should not be due on the 15th.

DMAS Response: This is something that will be taken back and evaluated. We are not making any changes at this time.

23. Comment: One commenter shared concerns about the operation of the Therapeutic Consultation service. They have questions related to the scope of the service and documentation requirements.
DMAS Response: DMAS has reviewed the suggestions in the comment and will use them to make clarifications in program guidance as needed.
24. Comment: One commenter expressed support for the alignment of quality measures.
DMAS Response: We thank you for your comment. We think that the clean up done on the quality measures will improve the efficiency of the quality review process.
Comment: One commenter expressed opposition to allowing DD waiver individuals to hold onto a slot for up to 1 year prior to enrollment, citing the Priority 1 Waitlist.
DMAS Response: Thank you for your comment. DMAS has concerns that given many of the people at the front of the DD Waiver Waitlist are individuals have an imminent demand for waiver services would now argue they need an additional year before electing to use any services.

Regarding the Use of Telehealth:

Regarding the use of telehealth for identified activities of services: Since the COVID-19 pandemic, higher rates of use of telehealth have become standard across many elements of the healthcare and behavioral health practices. The addition of telehealth options to some Virginia Waiver services is not intended to supplant community integration, but rather to complement it. The ability for individuals to connect with providers via HIPAA compliant remote platforms offers the opportunity to prepare and/or plan for community integration opportunities in secure and lower stress environments. The services that serve a community integration purpose are not eligible for 100% telehealth delivery.

Enrolled VA Medicaid providers are required to render services that meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)."

Services that permit telehealth as a delivery option in the Community Living Waiver include: Group Day; In-Home Support, [Individual and Group] Supported Employment. Service Facilitation, Benefits Planning, Community Coaching, Community Engagement, Community Guide, Peer Mentoring, Therapeutic Consultation, and Workplace Assistance.
"Telehealth services" means the use of telecommunications and information technology to provide access to health assessments,

diagnosis, intervention, consultation, supervision, and information across distance for both medical and behavioral health services. Telehealth services includes the use of such technologies as interactive and secure medical tablets, remote patient monitoring, and store-and-forward technologies. When delivering services via telehealth, providers are required to adhere to the same standards of clinical practice and record keeping that apply to other covered services. providers must assure the same rights to confidentiality and security as provided in face-to-face services. Providers must ensure the individual's informed consent to the use of telehealth and advise members of any relevant privacy considerations. Providers shall maintain appropriate documentation to support medical necessity for the service delivery model chosen, as well as to support medical necessity for the ongoing delivery of the service through that model of care.
Applicable to all services with a telehealth option:

Justification for telehealth being an appropriate service delivery modality is to be included in the state's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth model.
The support coordinator/case manager will complete an attestation form [at least] annually. It is to be signed off on by all parties: the individual and/or legal decision maker; any relevant provider offering telehealth services for the individual; and the support coordinator/case manager. The attestation form verifies the individual has selected telehealth for the delivery of services and is appropriate for the individual. As appropriate, the support team will evaluate the individual's overall progress on identified goals and determine if telehealth delivery is having an impact on progression. Providers are to have information available for the individual and/or unpaid caregiver on how to access and utilize their telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology benefit of the waiver, provided all appropriate criteria apply. Waiver shall not be authorized for the provision of internet services. The state shall monitor compliance with these expectations via the approved quality management review process (QMR).
The state acknowledges that telehealth does not substitute for in-person health and welfare guards. Providers opting to render services via a telehealth model are mandatory reporters for abuse, neglect and/or exploitation and are required to report any suspected abuse, neglect, or exploitation immediately.

APPENDIX I-2A : Addendum
CUSTOMIZED RATE:
Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs fall outside of the supports that are available and funded through the standard rate for their assigned reimbursement tier. These individuals have exceptional medical and/or behavioral support needs and require 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them. These individuals may require higher level supports in order to avoid placement in a state operated mental health or DD facility, or in a more restrictive environment. They are often identified as those who require greater support in order to find in-state providers willing to serve them.
Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports. In addition, these individuals may require the supervision and oversight required by more experienced/highly trained direct support staff or require clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.
Medically, an individual may require 1:1 or 2:1 staff support when they have a health history or recent health complication that puts them at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during mealtime due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that they may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff may be necessary during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.
SERVICES THAT MAY QUALIFY FOR A CUSTOMIZED RATE:
A. Supported Living, B. In-Home Support services, C. Community Coaching, D. Group Day, E. Sponsored Residential, F. Group Home

CUSTOMIZED RATE DETERMINATION:
DBHDS has developed a customized rate review team comprised of developmental disability subject matter experts to include a registered nurse and behavioral specialist. The team will review applications to determine if a customized rate is appropriate based on the below listed criteria:
Provider adequately proves through documented protocols, Individualized Support Plans, quarterly reports, and application submission that:
1. The individual has exceptional support needs that outweigh the current waiver rate structure in either medical, behavioral or both and requires a staffing ratio of 1:1 or higher for all or some of their daily support needs And
2. The individual requires more highly qualified staff to safely and effectively provide direct supports Or
3. The individual requires increased programmatic oversight defined as oversight that is provided by highly qualified staff (Bachelor's level or higher) that requires a higher level of expertise than routinely required.
After the determination is made, a rate model specific to the service will be used to determine the rate approved. For specialized staff, DBHDS has specified wage levels that are to be used when approving customized rates. In particular, the wage assumption for these staff is set at 115 percent of the wage assumption for the 'standard' assumed wage for the applicable service. Other assumptions (benefits and productivity for direct care staff, agency overhead - except when a variable program support is negotiated for residential services, etc.) are the same as in the standard rate model for the applicable service.
A Customized Rate is approved based on either a fixed rate or a flexible rate.
A. A Fixed rate (In home residential, community coaching, group day) is a type of Customized Rate approval whereby the rates are pre-determined and are approved based on demonstrated needs for either a higher level of staff credentialing or a higher staff-to-individual ratio of supports, or both being required. Fixed Customized rates are fixed based on region (Northern Virginia/ Rest of State), staffing ratio (one-to-one or two-to-one), and staff qualifications ('standard' or 'specialized'). These rates were constructed by making relevant adjustment to the underlying rate model for the applicable service. Fixed rate customized rates are approved for a fixed dollar amount above the standard rate. The total hours billed at this rate must be determined by the provider and approved by service authorization.
B. A Flexible rate (Group home, sponsored residential, supported living) is a type of Customized Rate approval that is individually determined and is variable, based on eligibility criteria such as the number of hours of increased staffing, increased level of Programmatic Oversight, and/or increased level of direct support credentialing required. The amounts that are agreed to by DBHDS are input into an Excel-based workbook that calculates the resultant rate for the individual. In particular, DBHDS can specify additional staffing levels, the use of 'specialized' staff (the wages for whom are priced at 115 percent of the wage for 'standard' staff), and the total amount of program support specifically designed to meet the unique needs of the individual. Other costs in the rate - such as mileage and administration - are fixed at the same amounts in the underlying rate model for the applicable service. The total supports combined replace the standard rate for the specified service.
Once approved, DBHDS will make all necessary notifications of either approval or denial, enter the approved rate into WaMS, and notify the individual/provider of their appeal rights.
All individuals approved for a customized rate, regardless of service type will be reviewed at least annually. Providers will be required to complete a new customized rate application and submit updated/recent supporting documentation at the time of the review.

Continued from Appendix I2a

Rate and reimbursement methodologies for services not included in the rate-setting effort described above are as follows:
• For Supported Employment-Individual services, providers are reimbursed at the same rate as their agreements with the Department of Aging and Rehabilitative Services (DARS) in order to encourage the seamless delivery of employment supports. DARS establishes each provider's Supported Employment rates upon application and on an annual basis. Through a Purchase of Service Application, which is similar to a cost report, new provider's rates are calculated by dividing budgeted costs by budgeted service hours. Budgeted costs include employee compensation allocated to services, professional fees, supplies, communications, building expenses, rental and maintenance of equipment, printing and publications, travel, training, membership dues, non-mortgage interest and capital depreciation.
• Reimbursement for Environmental Modifications, Assistive Technology, and Electronic Home-Based Supports is based on approved cost up to a $5,000 annual limit. Reimbursement for Transition Services is based on approved cost up to a $5,000 lifetime limit. Reimbursement for Individual and Family/ Caregiver Training is based on approved cost up to a $4,000 annual limit.
• For Personal Emergency Response Services, which has low utilization and few providers, the Commonwealth's rates were

compared to the rates paid by other states in order to ensure reasonableness. PERS monthly monitoring rates were identified in 1915(c) waivers for persons with intellectual and developmental disabilities in twenty-two other states for validation. This comparison found that the average Virginia rate falls within the third or middle quintile of these other states.

- Rates for Community Guide and Employment and Community Transportation services followed a similar process as the overall rate setting methodology as described above except that there was not a provider survey (because of a limited number of providers to provide the services and thus obtain valid data from a survey).

Similar to other DD services, Virginia developed the Community Guide, Peer Mentoring Supports, and Community Transportation using independent rate models. These models reflect the costs that provider face in delivering these services. The models account for various costs, including:

•The wage of the direct support professional
•Benefits for the direct support professional
•The productivity of the direct support professional (to account for non-billable responsibilities)
•Other direct care costs, such as transportation and program supplies
•Agency overhead costs
•Programmatic factors that affect per-person costs, such as staffing ratios

For Community Transportation, the state researched public and private transportation costs for various regions throughout the state. Transportation options included: bus, "Dial A Ride", Metrorail (Northern Virginia), taxi, and Uber. The research analyzed peak and non-peak fares for senior/disabled individuals, along with regular fares. The findings from this research were incorporated into this rate model.

The rate models for Community Guide, Peer Mentoring Supports, and Community Transportation are fully funded.

For Benefits Planning services, the waiver has adopted the rates paid by the Commonwealth's vocational rehabilitation program for the same services.

Benefits Planning consists of four categories: Pre-employment benefits review, Work Incentives Development or Revision, Resolution of SSA benefits issues, and Other services. There are a total of 17 allowable activities that are encompassed within the overall four categories. A person-centered plan is developed and based on the individual's needs and hours for each activity authorized. The service is reimbursed based on a single hourly rate.

1. The State intends to utilize hourly units of service. All service areas have the same hourly rate. The annual limit for services is $3,000 per year. The services will be authorized and reimbursed based on the person-centered planning process used to determine the activities needed and corresponding service hours.

2. Reimbursement may occur upon completion of each unit hourly unit of service.

The following information below consists of additional information for Appendix H.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information

Case Management Steering Committee (CMSC)

The CMSC is responsible for monitoring case management performance across responsible entities to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of case management services to meet individuals' needs in integrated settings, and evaluate data to identify and respond to trends to ensure continuous quality improvement. The CMSC may contribute to the development of remediation strategies for the QRT PM related to QSR reviews.

The CMSC ensures that the CSBs receive their case management performance data semi-annually at a minimum and produces a semi-annual report to the QIC on the findings from the data review with recommendations for system improvement. The CMSC report includes an analysis of findings and recommendations based on review of the information from case management monitoring/oversight processes, including data from the oversight of OL, QMR, CSB Case Management Supervisors Quarterly Reviews, CQI retrospective reviews, QSRs, and Performance Contract Indicator data.

Key Performance Areas (KPAs) Workgroup

The KPA Workgroup is an internal DBHDS workgroup comprised of three committees charged with organizing the activities of

the various DBHDS quality subcommittee activities across the established eight domains: physical, mental and behavioral health and well-being; avoiding crises; stability; choice and self-determination; community inclusion; access to services; provider capacity; and safety and freedom from harm. The DBHDS quality subcommittees and work groups report on performance measure indicators (PMIs) that are in alignment with the eight domains reviewed by the DBHDS QIC Risk Management Review Committee (RMRC)
The purpose of the RMRC is to provide ongoing monitoring of serious incidents and allegations of abuse and neglect, as well as analysis of individual, provider and system level data to make recommendations to promote health, safety and well-being of individuals. As a quality subcommittee of the QIC, the RMRC establishes uniform risk triggers and thresholds, implements processes to investigate reports of serious incidents, and identifies remediation steps. The RMRC develops and implements uniform risk identification and management tools used as a remediation strategy for PMs related to risk assessment and risk mitigation.

Appendix H Quality Improvement Strategy*
The Commonwealth's Quality Improvement Strategy under the waiver's assurances is founded in the principles of Continuous Quality Improvement and the design, discovery, and remediation cycle. The approach utilizes review of evidence to identify areas of need, attempts to pinpoint the reasons for low performance, and develop interventions aimed at correcting deficiencies in a manner that promotes full community participation and engagement, while balancing the health, safety, well-being, and quality of care of individuals in services.
In operationalizing the Quality Improvement Strategy, each of the above-mentioned departmental entities draw from their combined evidence from reviews and subject matter expertise to address system gaps that lead to low performance and propose solutions to address these areas. These departmental entities function as quality improvement subcommittees, which together, represent a comprehensive view of the quality of services in the Commonwealth. Each quality improvement subcommittee reports on targeted performance measure indicators (PMI's), which allow for tracking the efficacy of preventative, corrective and improvement initiatives, and are used to prioritize quality improvement initiatives within the state. The PMI's are aligned with the performance measures under the waiver assurances and used to ensure consistency and accountability of performance statewide. All DHBDS quality improvement subcommittees are overseen by the QIC, which provides cross-functional, cross-disability data and triage to the quality subcommittees. The QIC works within an ongoing organizational strategic quality improvement plan that serves as a monitoring and evaluation tool for the state. The state's quality improvement framework within DBHDS oversees the various quality initiatives of the quality subcommittees to ensure all are working together to support the quality assurance priorities of the Commonwealth directed by the QIC.
Communication with Stakeholders
Information about recommended systems changes and their outcomes are communicated to stakeholders through a variety of forums, including quarterly RQC meetings, QIC meetings, quarterly Settlement Agreement Stakeholder meetings, as well as annual quality improvement reports posted on the DBHDS website. Several of these also offer stakeholders the opportunity to express their concerns and suggestions to DBHDS.
The QRT also prepares an End of Year Report regarding compliance levels with the waiver PMs. The CSBs are required to review the report and provide comments back to DBHDS regarding their related QI plans, as well as provide suggestions to the QRT for systemic improvements. The QRT reviews these suggestions and discusses ways to implement them. The End of Year Report is made available to the public on the DBHDS website.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been

identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Department of Behavioral Health and Developmental Services (DBHDS)

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DMAS is responsible for appeals, conducting quality management reviews, contract monitoring of service authorization, paying provider claims and completing federal reports, including the demonstration of cost effectiveness. DMAS and DBHDS work together to develop provider rates and ensure budget monitoring and accountability. DBHDS has an active role in the development of the waiver, development of provider (policy) manuals and regulations, development of state plan amendments, leadership of advisory groups of stakeholders, development of provider communications and official memoranda and responses to the public and legislators about concerns regarding the waiver, slot distribution and service authorization procedures and functions. DBHDS also manages the related waiting list and provides training, technical assistance and consultation.

The DMAS-DBHDS Interagency Agreement (dated January 2024) further describes and emphasizes the roles and responsibilities of the two agencies. It is reviewed annually and updated to ensure it reflects the current arrangement and is modified if changes or additions are needed.

DBHDS, the operating agency, is the Commonwealth's single state agency for public mental health, developmental and substance abuse services. As the agency responsible for the daily policy development and management of the Community Living Waiver, DBHDS's responsibilities include:

1) DBHDS will certify to DMAS for purposes of provider enrollment the licensing status of programs and services licensed by DBHDS, as needed.

2) DBHDS will actively participate in and advise DMAS as DMAS develops new managed care projects that include or affect any Medicaid-reimbursed mental health, intellectual disability, or substance use disorders services.

3) Subject to review and approval by DMAS, DBHDS may subcontract services to other qualified organizations.

4) The DBHDS Licensing Office will inform DMAS when negative action, such as sanctions or license revocations, have been initiated.

5) DBHDS will serve as an expert witness, as needed, in provider and client appeal cases.

6) DBHDS will provide data on a routine basis and as needed to respond to reporting requirements of CMS.

7) DBHDS shall maintain a listing of providers licensed by DBHDS on their website.

8) DBHDS will coordinate with the CSBs to obtain the information and needed by DMAS for approval or denial of all out-of-state placements recommended by DBHDS.

9) DBHDS shall manage daily operations and recommend design changes to the waiver for individuals with I/DD, with review and final approval by DMAS.

10) DBHDS shall develop regulations, policy, procedures, provider memoranda, State Plan Amendments, and CMS Waiver applications and subsequent amendments for the waivers for individuals with I/DD, with the input, review and final approval and submission by DMAS to the appropriate federal and state authorities.

11) DBHDS shall manage the waiver waiting lists and distribute slots to the Community Services Boards according to established criteria, procedures and CMS approved waiver applications. DBHDS shall develop a consistent set of guidelines to be applied statewide for slot assignment by the Community Services Boards. DBHDS will monitor the assignment of slots by the Community Services Boards necessary to comply with CMS requirements defined in the waiver.

12) DBHDS shall address questions and concerns from the public or legislators regarding waivers and slot distribution.

13) DBHDS will convene and serve as lead of advisory committees that pertain to these waivers.

14) DBHDS shall conduct the training, and provide the technical assistance, and consultation on these waivers

and waiver-related services, and participate in training with DMAS.

15) DBHDS shall collaborate with DMAS in the development of the budget and agency funding priorities. DMAS shall provide data as needed to support this function and actively participate in the development process.

16) DBHDS shall include in its budget priorities and budget proposals funding for Waiver slots and Waiver program services.

17) DBHDS and DMAS shall perform quality management review functions to assure compliance with CMS waiver requirements and jointly meet as mutually agreed to review findings and recommend program enhancements.

18) The State-designated agency or its contractor shall perform prior authorization for the waivers for individuals with I/DD.

19) The two agencies will meet the performance measures and assurances as set forth by CMS for waiver applications that are operated by DBHDS.

DMAS, the single state agency maintains the following responsibilities for the administration of Medicaid-funded programs:

1) DMAS will develop and maintain the State Medical Assistance Plan, which is approved by the Centers for Medicare and Medicaid Services (CMS).

2) DMAS shall complete federal quarterly and other reports, including the demonstration of cost effectiveness and outcome measure reporting, for CMS. DMAS shall provide DBHDS sufficient notice of its need for information, provide review and comment by DBHDS and supply to DBHDS copies of reports made pursuant to this section.

3) DMAS will submit approved waiver documents and State Plan Amendments relating to waivers to CMS, following review and comment by DBHDS, with a final copy to DBHDS.

4) DMAS will participate in the development and review of and have final approval authority for all revisions made to policies, provider manuals, regulatory packages, State Plan Amendments, or amendments to the Code of Virginia.

5) DMAS shall review, sign, and send Medicaid memoranda to DBHDS to assure individuals and providers are informed as needed.

6) DMAS will pay valid provider claims submitted by qualified providers for covered services.

7) DMAS will collaborate with DBHDS in developing budget proposals and submissions and requests for funding in the Governor's budget for covered services.

8) DMAS has the right to terminate or retract payment to a provider due to licensing, health and safety issues or quality management or utilization review findings.

9) DMAS will respond to the public and legislators regarding claims processing and any other functions that are carried out solely by DMAS and over which DMAS has final authority.

10)DMAS will maintain provider agreements with community services boards and other providers and ensure that all providers meet applicable qualifications and render covered services to Medicaid-enrolled individuals. DMAS will notify DBHDS of providers of the services.

11) DMAS will notify the DBHDS, Division of Developmental Services and Office of Licensing for providers licensed by DBHDS, when significant quality of care issues are identified or when DMAS has a reasonable basis for believing that a provider is experiencing significant financial difficulties.

12) DMAS will receive and manage provider and client appeals and provide DBHDS copies of appeal decisions.

13) DMAS will keep DBHDS informed of changes in missions and policies of DMAS and CMS, forward related communications with CMS to DBHDS and facilitate regular collaborative discussions with DBHDS and CMS to ensure compliance with state and federal statutory and regulatory requirements.

14) DMAS will participate as requested in advisory groups of stakeholders.

15) DMAS shall serve as the lead for all of out-of-state waiver placements, in accordance with the Division of Long-Term Care regulations, policies and procedures.

16) DMAS and DBHDS shall place on their respective web sites provider manuals, links to the other agency's website and any other information and documents needed by Medicaid providers.

17) DMAS shall provide information and data to DBHDS as needed to ensure the ability of DBHDS to carry out its responsibilities as outlined below.

18) DMAS will be responsible for provider rate-setting in consultation with DBHDS for rates under the DD waivers. DMAS will provide notice to providers about DD waivers rate changes. Final determination of all DD waivers rates paid remains with DMAS.

19) On a quarterly basis, DMAS shall, in collaboration with DBHDS, monitor the costs associated with the two Waivers to ensure that the services provided remain cost effective.

20) DMAS will monitor prior-authorizations conducted by the State-designated agency or its contractor for criteria application, entry into Virginia Medicaid Enterprise System (MES) and processing time. DMAS will provide DBHDS a summary of findings and collaboratively work with DBHDS to correct any identified issues.

The two agencies work collaboratively to resolve issues that arise and require final approval by DMAS. DMAS provides guidance and oversight of DBHDS activities via joint quarterly operations meetings where issues are discussed and resolved. These meetings include collaborative efforts to develop performance measures, monitor progress toward those meeting those measures and identify barriers to completion. This group also identifies issues that may need to be addressed through the waiver, regulations or policy and procedure manuals.

DMAS' and DBHDS' staff also meet quarterly as a Quality Review Team (QRT) to review data, survey results and information used to monitor progress toward meeting CMS assurances and take steps to conduct remediation where it is indicated. The QRT also identifies trends and areas where systemic changes are needed to collect new data and information or improve its quality.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Virginia DMAS contracts with other entities to perform the following roles:

1) Provider Enrollment Services for completion of provider enrollment, execution of provider agreements and management of the Virginia MES/MMIS. Information on their services can be found at https://vamedicaid.dmas.virginia.gov.

2) A Fiscal/Employer Agent(FEA) is contracted to perform the functions of the fiscal management services for consumer-direction. The FEA conducts payment activities on behalf of the individual receiving consumer-directed services. The FEA is responsible for calculating and filing all employer related taxes and makes payment to attendants on a bi-weekly basis. As of 3/1/2027, the FEA will also employ support brokers to provide information and training in support of consumer direction. The support brokers will be responsible for conducting visits to ensure the adequacy and appropriateness of consumer-directed services, develop the Plan of Care for consumer-directed services based on an assessment of the individual, submit service authorization requests for consumer-directed services, and provide initial training to and act as a resource to answer questions for the Employer of Record.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Three main functions of the waiver administration and operation are performed in part by the local Community Services Boards/Behavioral Health Authorities (CSBs). These are facilitating individual waiver enrollment, conducting the level of care evaluation, and coordinating the development of Individual Support Plans prior to service delivery. These functions are completed by case managers employed or contracted by the CSBs as part of their Virginia statute dictated role as the single point of entry into the publicly-funded mental health, developmental, and substance abuse service system. In addition, these three functions are validated by DBHDS staff, who receive and review summaries of these elements from the CSBs/BHAs as part of the individual enrollment and service authorization processes, according to the DMAS-DBHDS Interagency Agreement. All of these functions are subject to review by the state Medicaid Agency through routine Quality Management Reviews.

CSBs are single or multiple jurisdictional entities established by local governments pursuant to section 37.2-500 or 37.2-600 of the Code of Virginia and are under the control of local elected officials (city council and board of supervisors' members who establish the CSB, approve its annual "performance contract" with DBHDS and appoint CSB board members.) The performance contract with which each CSB enters with DBHDS is for the purpose of funding services provided directly or contractually by the CSB in a manner that ensures accountability to DBHDS. It also ensures quality of services for individuals and implements the vision (articulated in DBHDS State Board Policy 1036, the DBHDS Vision Statement) of an individual-driven system of services and supports. This contract defines requirements and responsibilities for the CSB and DBHDS such as the scope of services to be provided, the population to be served, resource management, board responsibilities, state Department responsibilities, reporting requirements and dispute resolution.

DMAS additionally maintains a provider agreement with each CSB to support the provision of the above listed (and other) case management functions.

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Virginia Department of Medical Assistance Services (DMAS) maintains responsibility for assessing the performance of contracted entities. DMAS employs contract monitors to oversee the daily administrative operations of these contracted entities and to provide periodic evaluation of the outcomes and deliverables (described in the next section.)

As outlined in the Code of Virginia, the DBHDS functions as the state authority for the public mental health, developmental, and substance abuse services system; and Community Services Boards and the Behavioral Health Authorities (CSBs) function as the local authorities for that system. The relationship between and the roles and responsibilities of the Department and CSBs are described in applicable provisions of the Code of Virginia, State Board of Behavioral Health and Developmental Services policies, and the community services performance contract negotiated annually by the DBHDS with each CSB. DBHDS and CSBs enter into the performance contract to fund services provided directly or contractually by the CSBs in a manner that ensures accountability to DBHDS and quality of care for individuals receiving services and implements the DBHDS vision of a system of services and supports driven by individuals receiving services that promote self-determination, empowerment, recovery, resilience, health, and the highest possible level participation by individuals receiving services in all aspects of community life, including work, school, family, and other meaningful relationships.

The performance contract requires that the CSB address and report on performance expectations and goals as part of the Continuous Quality Improvement Process supported by the Department. The CSB must report required data to the DBHDS about the demographic characteristics of individuals receiving services and the types and amounts of services it provides. The contract requires the CSB to account for all services, revenues, expenses, and costs accurately and submit reports to the Department in a timely manner. The performance contract is available on the DBHDS web site at https://dbhds.virginia.gov/office-of-management-services/.

For its part, the DBHDS disburses state general funds to each CSB subject to the CSB's compliance with the provisions of the performance contract. The DBHDS provides guidance, direction, and technical assistance to CSBs, licenses and monitors CSBs and other providers, and has the authority under the contract to utilize a variety of remedies, including requiring a corrective action plan, delaying payments, and terminating all or part of the contract, to assure CSB compliance with the contract.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DMAS is responsible for the assessment of performance of all contracted entities, that perform waiver operational and/or administrative functions. Medicaid agency employees are assigned the duties of contract monitor to oversee and ensure the performance of the contracted entities and complete an evaluation every six months. Contract monitors are responsible for:

1) Coordinating and overseeing the day-to-day delivery of services under the contract, including assurance that information about the waiver is given to potential enrollees; that individuals are assisted with waiver enrollment; that level of care evaluations are completed; that waiver requirements are met according to the individual support plan; and that prior authorization is conducted in accordance with review criteria and approved procedures;
2) Ensuring that services are delivered in accordance with the contract and that deliverables are in fact delivered;
3) Approving invoices for payment in accordance with the terms of the contract;
4) Completing and submitting a semi-annual report to the DMAS Contract Officer;
5) Reporting any delivery failures or performance problems to the DMAS Contract Officer; and
6) Ensuring that the contract terms and conditions are not extended, increased, or modified without proper authorization.

The evaluation measures include:
1) Has the contractor/agency complied with all terms and conditions of the contract/agreement during the period of this evaluation?
2) Have deliverables required by the contract/interagency agreement been delivered on a timely basis?
3) Has the quality of services required by the contract/interagency agreement been satisfactory during the evaluation period?
4) Are there any issues or problems you wish to bring to managements attention at this time?
5) Do you need assistance in handling any issues or problems associated with the contract/interagency agreement?
6) From an overall standpoint, are you satisfied with the contractors/agency's performance?

In addition, DMAS oversees DBHDS as the operating agency, through annual monitoring of the interagency agreement, program and financial audits, ongoing quality management reviews and quarterly meetings of agency staff in the form of operational monitoring. In addition the DMAS-DBHDS Quality Review Team (QRT) meets quarterly to review data on the performance of providers, performance deficiencies, select remediation strategies, and determine the impact of implementing such strategies on individual issues and the overall system. The functions of the QRT are described fully in Appendix H.

DMAS reviews audit findings and corrective action plans to ensure that any deficiencies identified are remediated.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☐	☑

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Waiver enrollment managed against approved limits	☑	☑	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☐	☐
Level of care waiver eligibility evaluation	☑	☑	☐	☑
Review of Participant service plans	☑	☑	☐	☑
Prior authorization of waiver services	☑	☑	☐	☑
Utilization management	☑	☐	☐	☐
Qualified provider enrollment	☑	☐	☑	☐
Execution of Medicaid provider agreements	☑	☐	☑	☐
Establishment of a statewide rate methodology	☑	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☐	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
AA2. Number and percent of DBHDS provider memorandums pertaining the waiver approved by DMAS prior to being issued by DBHDS. N: # waiver provider memorandums issued by DBHDS that were approved by DMAS prior to being issued D: Total # of waiver provider memorandums issued by DBHDS.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA1. Number and percent of satisfactory Medicaid-initiated operating agency and contractor evaluations. N: # of satisfactory Medicaid-initiated operating agency and contractor evaluations D: Total # of Medicaid-initiated operating agency and contractor evaluations.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA3. Number and percent of slots allocated to CSBs in accordance with the standard, statewide slot allocation process. N: # of slots allocated statewide according to the standardized process D: # of slots allocated statewide

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBHDS reports for slot allocation

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DMAS meets with the operating agency (DBHDS) quarterly (in the context of the Quality Review Team meeting) and as needed to review performance and discuss how problems identified will be remediated. Follow-up letters are sent by DMAS and reports are requested on the status of remediation and individual problems. DMAS may provide training and technical assistance to ensure problems that have been identified are resolved.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ● **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ● **Not applicable. There is no maximum age limit**
- ○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ● **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible

individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*.

The limit specified by the state is *(select one)*

- **A level higher than 100% of the institutional average.**

  Specify the percentage:

- **Other**

  Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	12558
Year 2	12733
Year 3	

Waiver Year	Unduplicated Number of Participants
	12733
Year 4	12733
Year 5	12733

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- ○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ● **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	12348
Year 2	12520
Year 3	12520
Year 4	12520
Year 5	12520

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ● **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Facility Reserve	
Waiver Movement and Emergencies	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Facility Reserve

Purpose *(describe):*

To enable individuals to transition from an ICF-IID,SNF, or other institutional setting to the community in compliance with requirements of the 2012 Settlement with the U.S. Department of Justice.

Describe how the amount of reserved capacity was determined:

Slots for facility downsizing are funded by the Virginia General Assembly according to the Commonwealth's Settlement Agreement with the US Department of Justice.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Waiver Movement and Emergencies

Purpose *(describe):*

Because the Commonwealth's three waivers for persons with DD (the Community Living, the Family and Individual Supports and the Building Independence waivers) all support individuals who access them from the same statewide waiting list, it is highly desirable for individuals on one of the three waivers not to have to wait to access a waiver with a different focus and set of services. Therefore, having a pool of reserve slots is desirable so that individuals already receiving services in one of the other two DD waivers who experience a change in their assessed needs may move seamlessly to the Community Living waiver when needed.

This set of reserve slots will also provide a safety net to individuals who move from the Community Living waiver to one of the other two DD waivers That way individuals who find that their "new waiver" does not meet their needs as originally thought can return to the original (Community Living) waiver if needed.

Some of these slots will be used as emergency capacity slots for individuals who are either on the statewide waiver waiting list or are previously unknown to the DD system to ensure their health and safety in an emergency situation (e.g., being homeless or facing imminent homelessness). These emergency slots will be made available to individuals experiencing emergencies on a first come-first served basis.

Describe how the amount of reserved capacity was determined:

The reserved capacity was determined by the amount of reserved waiver slots allocated by the Virginia General Assembly.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	55
Year 2	55

Waiver Year	Capacity Reserved
Year 3	55
Year 4	55
Year 5	55

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ○ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ● **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ○ **Waiver capacity is allocated/managed on a statewide basis.**
- ● **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

Virginia currently has a waiting list for waiver services for individuals with I/DD. With the initiation of its three amended waivers, this statewide, needs-based waiting list will consist of individuals grouped according to priority of needs. The overall, statewide waiting list is managed by the Virginia DBHDS.

When at least 40 new waiver slots are funded by the General Assembly, one slot will be allocated to each CSB. Additional slots, up to the total number of available slots for a given waiver, will be allocated to CSBs for individuals living within that CSB's catchment area based upon a weighted formula which will factor the following objective factors/criteria:

- the region's population
- the percentage of Medicaid eligible individuals in the catchment area
- each CSB's percentage of individuals on the "Priority One" portion of the statewide waiting list.

When the General Assembly has approved less than 40 slots for a given waiver, the available slots will be divided between regions/sub-regions for distribution to the individual(s) in that region/sub-region who are determined to have the most urgent needs.

Individuals have comparable access to waiver services across the geographic areas served by the waiver due to the fact that slots are distributed in the above manner. This ensures that individuals in all areas of the state have an opportunity to receive waiver services, based on the urgency of their need, and areas with a high concentration of individuals with urgent need receive a greater share of slots in order to meet those needs. Individuals may receive waiver services in any area of the state.

Once allocated to a CSB or a regional/sub-regional group of CSBs, slots are assigned to individuals based on priority of need by a group of DBHDS trained, impartial volunteers from the area/region. These committees, known as Waiver Slot Assignment Committees (WSACs), review the needs of the highest scoring individuals within that region/sub-region. The entity which places the individual on the waiting list (i.e., CSB) may not determine who receives the next available slot.

When more than 40 newly funded slots are available in both the CL and FIS waivers at the same time, those slots will be allocated to the individual CSB according to the above methodology. Committee members will determine those in most need of a slot within the CSB based upon the total slots available between the CL and FIS waiver without knowledge of how man slots per referenced waiver. Once the WSAC has made the selection of individuals, DBHDS staff will then pair those individuals with the type of waiver slot that will best meet each individual's needs (e.g., individuals with documented needs for a residential services only available in the CL waiver, such as group home residential, will be assigned a CL slot, while individuals seeking supports in the family or individual's own home will be assigned a FIS slot).

When a waiver slot becomes available through attrition, that slot must be assigned by the CSB's WSAC to the individual who is determined to have the highest priority of need at that time in that CSB's catchment area.
If vacated slots cannot be assigned to an individual from the same CSB within 90 days, the slot is released to the CSBs within that region for distribution to individual in that region with the highest priority of need. If there should be no one on the "Priority One" portion of the statewide waiting list within the region, DBHDS will reallocate the slot to another region or CSB where there is unmet Priority One need.

Just as individuals retain their waiver slot when they move from one part of the state to another, individuals remain on the statewide waiting list regardless of movement from area to area within the state.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Waiver slot assignment is the pairing of an available (funded) waiver slot with the individual in most urgent need at the time. The slot assignment process is designed to ensure that the individual with the most urgent need in a particular locality receives a slot ahead of those with less urgent needs. Only individuals who need waiver services within 30 days and are at imminent risk of institutionalization will be assigned a waiver slot per 42 CFR 441.302.C.1-3.

Due to the fact that Virginia currently has a waiting list for individuals seeking DD waiver services, individuals who meet the diagnostic, level of care and financial criteria must also be found to meet criteria for priority of need in order to receive a slot. This must be documented in the individual's record and a sample of individuals on the waiting list is reviewed by DMAS Quality Management Review staff during their onsite reviews to assure that the criteria is being applied correctly.

There will be one waiting list from which individuals are selected for all three waivers. The waiting list will be divided into three categories: Priority One, Priority Two and Priority Three. Only when all individuals across the state in the Priority One category have been served may Priority Two (and then Priority Three) individuals access a DD waiver slot.

1. Priority One: individuals determined to meet one of the following criteria and require a waiver service within one year.
a. An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.
b. There is immediate risk to the health or safety of the applicant, primary caregiver, or other person living in the home due to either of the following conditions:
(1) The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with services coordinator/case manager-arranged generic or specialized supports; or
(2) There are physical care needs, such as lifting or bathing, or medical needs that cannot be managed by the primary caregiver even with services coordinator/case manager-arranged generic or specialized supports;
c. The individual lives in an institutional setting and has a viable discharge plan; OR
d. The individual is a young adult transitioning who is no longer eligible for IDEA services . After age 27, this criterion will no longer apply.

2. Priority Two: individuals meet one of the following criteria and a service is needed in one to five years.
a. The health and safety of the individual is likely to be in future jeopardy due to
i. The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual;
ii. There are no other unpaid caregivers available to provide supports; and
iii. The individual's skills are declining as a result of lack of supports;
b. The individual is at risk of losing employment supports;
c. The individual is at risk of losing current housing due to a lack of adequate supports and services; or
d. The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

3. Priority Three: the individual may not need to access a waiver slot for more than five years as long as the current supports and services remain.
a. The individual is receiving a service through another funding source that meets current needs;
b. The individual is not currently receiving a service but is likely to need a service in five or more years; or
c. The individual has needs or desired outcomes that adequate supports will result in a significantly improved quality of life.

Individuals who are in the Priority 1 category who are determined to be most in need of supports at the time a slot is available are reviewed by the independent Waiver Slot Assignment Committee for the area in which the slot is available. The individual whose score indicates the highest need as designated by the committee, is offered the available slot. The committee reviews twice the number of people as available slots.

Between the three DD waivers, assignment to a slot in the Family and Individual Supports (FIS) waiver will typically take precedence. Individuals may be considered for a slot in one of the other two DD waivers based upon the following:
- The individual's needs cannot be met within the FIS Waiver due to the level and intensity of supports required,
- The individual is requesting and has a demonstrated need for services which are not available within in the FIS

Waiver, nor can be coordinated with EPSDT (for children), or
• The individual is in an emergency status or found to have the highest priority of need at the time a slot is available and, while the FIS waiver can meet his/her need, the only available slot is in another waiver.

Individuals may request a reserve slot in order to transfer to another waiver based upon the following:
• The individual desires to live more independently and shift to a different waiver (i.e., movement from the Community Living waiver to the FIS Waiver or from either of those to waivers to the Building Independence waiver), or
• The individual is confirmed to have imminent increasing support needs and requires more intense services available in another waiver.

Appeal rights are given to individuals who move from the previous urgent waitlist to Priority 2 or 3, and from non-urgent to Priority 3.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 07/01/24

a. The waiver is being (select one):

- (●) **Phased-in**
- ( ) **Phased-out**

b. Phase-In/Phase-Out Time Schedule. *Complete the following table:*

Beginning (base) number of Participants: 12176

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 12558

Month	Base Number of Participants	Change	Participant Limit
Jul	12176	43	12219
Aug	12219	0	12219
Sep	12219	0	12219
Oct	12219	43	12262
Nov	12262	0	12262
Dec	12262	0	12262
Jan	12262	43	12305
Feb	12305	0	12305
Mar	12305	0	12305
Apr	12305	43	12348
May	12348	0	12348
Jun	12348	0	12348

Waiver Year 2
Unduplicated Number of Participants: 12733

Month	Base Number of Participants	Change	Participant Limit
Jul	12348	43	12391
Aug	12391	0	12391
Sep	12391	0	12391
Oct	12391	43	12434
Nov	12434	0	12434
Dec	12434	0	12434
Jan	12434	43	12477
Feb	12477	0	12477
Mar	12477	0	12477
Apr	12477	43	12520
May	12520	0	12520
Jun	12520	0	12520

Waiver Year 3
Unduplicated Number of Participants: 12733

Month	Base Number of Participants	Change	Participant Limit
Jul	12520	0	12520

Waiver Year 4
Unduplicated Number of Participants: 12733

Month	Base Number of Participants	Change	Participant Limit
Jul	12520	0	12520

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Aug	12520	0	12520
Sep	12520	0	12520
Oct	12520	0	12520
Nov	12520	0	12520
Dec	12520	0	12520
Jan	12520	0	12520
Feb	12520	0	12520
Mar	12520	0	12520
Apr	12520	0	12520
May	12520	0	12520
Jun	12520	0	12520

Month	Base Number of Participants	Change	Participant Limit
Aug	12520	0	12520
Sep	12520	0	12520
Oct	12520	0	12520
Nov	12520	0	12520
Dec	12520	0	12520
Jan	12520	0	12520
Feb	12520	0	12520
Mar	12520	0	12520
Apr	12520	0	12520
May	12520	0	12520
Jun	12520	0	12520

Waiver Year 5

Unduplicated Number of Participants: 12733

Month	Base Number of Participants	Change	Participant Limit
Jul	12520	0	12520
Aug	12520	0	12520
Sep	12520	0	12520
Oct	12520	0	12520
Nov	12520	0	12520
Dec	12520	0	12520
Jan	12520	0	12520
Feb	12520	0	12520
Mar	12520	0	12520
Apr	12520	0	12520
May	12520	0	12520
Jun	12520	0	12520

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
☑	☑	☐	☐	☐

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Jul	
Phase-in/Phase-out begins	Jul	1
Phase-in/Phase-out ends	Apr	2

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **Section 1634 State**
- ○ **SSI Criteria State**
- ● **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ● **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- ☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☐ **Pregnant Women (42 CFR § 435.116)**
- ☐ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- ☐ **Optional state supplement recipients**
- ☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ● **% of FPL, which is lower than 100% of FPL.**

Specify percentage: 80

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR § 435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Coverage for individuals age 19 or older and under age 65 in accordance with 435.119

Special home and community-based waiver group under 42 CFR § 435.217) *Note: When the special home and*

community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed

- ○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.** *Appendix B-5 is not submitted.*
- ● **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**
- ● **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

- ● **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage: [ ]

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

(*select one*):

- **The following standard under 42 CFR § 435.121**

  Specify:

- **Optional state supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**

  (*select one*):

  - **300% of the SSI Federal Benefit Rate (FBR)**
  - **A percentage of the FBR, which is less than 300%**

    Specify percentage:
  - **A dollar amount which is less than 300%.**

    Specify dollar amount:
- **A percentage of the Federal poverty level**

  Specify percentage:
- **Other standard included under the state plan**

  Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:

  The basic maintenance needs for an individual is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least 4 but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.
- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**
  Specify:

  Specify the amount of the allowance (*select one*):

  - ( ) **The following standard under 42 CFR § 435.121**

    Specify:

  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ] If this amount changes, this item will be revised.
  - ( ) **The amount is determined using the following formula:**

    Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- (●) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The state does not establish reasonable limits.**
- **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional state supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

Specify formula:

The basic maintenance needs for an individual is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least 4 but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

● **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

● **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ● **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Services must be provided at least quarterly. Case managers will continue to monitor all enrolled individuals on a monthly basis.

Monthly activity with the enrolled waiver individual is conducted by the Case Manager, to include a quarterly face to face interaction. Monthly activity includes a contact or collateral contact such as a visit or phone call to the individual, a family member, provider, physician etc. The face-to-face contacts must be completed at least quarterly

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ● **By an entity under contract with the Medicaid agency.**

Specify the entity:

The case manager (employed by or contracted with a CSB under contract with DMAS) performs both the level of care evaluation and reevaluation. The results of the evaluation/reevaluation are transmitted to DBHDS for review and confimation of eligibility.

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

For case management services to receive Medicaid reimbursement, individuals who engage in case management for individuals with ID and/or DD must meet and demonstrate the minimum knowledge, skills, and abilities as outlined in the Virginia Administrative Code as follows:

General DBHDS Licensing Case Management Requirements: 12VAC35-105-1250
DD Case Management: 12VAC30-50-490
ID Case Management: 12VAC30-50-440

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To ensure that Virginia's home and community-based waiver programs serve only individuals who would otherwise be placed in an ICF/IID, home and community-based waiver services shall be considered only for individuals who are eligible for admission to an ICF/IID. For the case manager to make a recommendation for waiver services, Community Living waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/IID, or promote exiting from either an ICF/IID placement or other institutional placement.

The tool used to determine level of care and waiver eligibility is called the Virginia Individual Developmental Disability Eligibility Survey, or "VIDES." It assesses the individual in eight functional areas:

1) Health Status
2) Communication
3) Task Learning Skills
4) Personal/Self Care
5) Motor Skills
6) Behavior
7) Community Living Skills
8) Self Direction

The items under the health, communication, task learning and behavior categories are scored as requiring assistance to one of the following degrees: "rarely," "sometimes," "often," "regularly."

The items under the personal/self care, mobility and community living skills categories are scored as requiring "no assistance," "prompting/structuring," "supervision," "some direct assistance" or "total care."

The items under Self Direction are scored positively or negatively.

The VIDES is used to assess level of care for individuals of all ages; however, there is an adapted version for children. There is a version of the VIDES for infants (birth through 2 years of age) and a version for children (three years through 17 years). The adult version is for those aged 18 and older. The adult and children's' versions of the VIDES assess individuals in the areas of health status, communication, task learning, personal/self-care, behavior, community living, and self-direction skills. The infants' version assesses those birth through 2 years in the areas of health status, communication, task learning, motor, and social/emotional skills. The state has been using the Virginia Individual Developmental Disability Eligibility Survey (VIDES) since 2016 to determine level of care. It is a revised version of the initial tool used by the state, the Level of Functioning (LOF). The state has been using the same tool to determine level of care for both the DD Waivers and ICF-IID (alternative level of care) for several years. The tool itself was revised in 2016 as part of the state's waiver redesign.

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

A comprehensive assessment process must be completed by the case manager to support the waiver level of care and determine the individual's need for services and supports provided by the waiver, as well as the individual's desired outcomes. This involves the case manager gathering relevant social, psychological, medical and level of care information and serves as the basis for the development of the individual support plan.

The case manager shall initially recommend the individual for waiver services after completion of a comprehensive assessment of the individual's needs and available supports. The comprehensive assessment includes:

a) Relevant medical information based on a medical examination completed no earlier than 12 months prior to the initiation of waiver services;
b) The assessment that demonstrates the individual's needs for specific services. The assessment must be a DBHDS approved assessment (currently the Supports Intensity Scale® completed by an independent contractor for most individuals aged 5 and older) completed following waiver enrollment;
c) The VIDES (level of care instrument) completed no more than six months prior to enrollment. The CSB determines whether the individual meets the ICF/IID criteria with input from the individual, his family/caregiver, as appropriate, and service/support providers involved in the individual's support in the community; and
d) The appropriate diagnostic evaluation that confirms DD. For individuals with an intellectual disability, this is a psychological evaluation that reflects the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individual. For an individual with a non-ID developmental disability, this may take the form of an evaluation by a physician or other professional licensed to make the determination of developmental disability as defined by Virginia Code (§ 37.2-100).

The case manager shall complete a reassessment annually in coordination with the individual and his family/caregiver, as appropriate, and service/support providers. The reassessment shall include an update of the level of care and other assessment as needed. If warranted, the case manager shall coordinate a medical examination or developmental disability diagnostic evaluation for the individual. The individual support plan shall be revised as appropriate.

The medical examination must be completed for adults based on need identified by the individual and his family/caregiver, as appropriate, provider, case manager, or DBHDS staff. Medical examinations and screenings for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

A new developmental disability diagnostic evaluation shall be required whenever the individual's functioning has undergone significant change and is no longer reflective of the past evaluation.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ● **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ● **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs

to ensure timely reevaluations of level of care *(specify):*

The State will employ the following procedures to ensure timely reevaluations of level of care:

1. Annual reevaluation is a component part of case management;
2. Case managers must annually report to DBHDS the date each level of care reevaluation is completed and the categories met; and
3. DMAS Quality Management Review staff will include monitoring of the completion of level of care reevaluations as a component of their on-site case management service reviews.

Case managers are required to re-evaluate the level of care no more than 365 days beyond the date of the last evaluation.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and reevaluations of level of care will be maintained in the following locations for a period of at least six years:

1. By the case manager (initial evaluations and reevaluations), and
2. By DBHDS (summaries of the results and dates completed for both initial levels of care and reevaluations).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC1. Number and percent of all new applicants who have a level of care evaluation prior to receiving waiver services. N: # of new applicants who have level of care evaluation prior to receiving waiver services D: total # of new applicants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Management System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC2. # & % of Virginia Individual Developmental Disability Eligibility Survey (VIDES) completed within 60 days of application for those for whom there is a reasonable indication that services may be needed in the future. N: # of VIDES completed within 60 days for new applicants D: total # of new applicants for whom there is a reasonable indication that services may be needed in the future.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Management System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC4. Number and percent of VIDES determinations for which the appropriate number of criteria were met to enroll or maintain a person in the waiver. N: # of VIDES determinations for which the appropriate number of criteria were met to enroll or maintain a person in the waiver D: total # VIDES determinations reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC3. # and % of VIDES determinations that followed the required process, defined as completed by a qualified CM, conducted face-to-face with individual and those who know him (if needed). N: # of VIDES determinations that followed the required process, defined as completed by a qualified CM, conducted face-to-face with individual & those who know him D: total # of VIDES determinations reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

CSB staff are given a certain number of records for each waiver (representative sample based on the number of individuals they support on each waiver) to review annually. The form that they must use includes questions from the performance measures and is located on Survey Monkey. Each quarter, these staff review approximately one quarter of their total assigned number of records and respond to the questions regarding each record. DBHDS staff reviews and summarizes the information for inclusion in the quarterly report regarding performance measures reviewed by DMAS and DBHDS staff.

DMAS and DBHDS have found that this is an effective means to ensure that CSB supervisors/QA staff are examining individuals' records with an eye to waiver performance measures expectations and providing feedback/remediation to their staff as needed. For each of the measures reviewed by CSB staff, there is typically another source of data (e.g., Quality Management Reviews).

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

For those performance measures initially reviewed by case managers, it is the responsibility of the case management supervisor or quality assurance staff to address problems related to the VIDES and report their resolution to the Quality Review Team (QRT) through DBHDS on a quarterly basis. The results of the record reviews, as well a the actions taken by these staff persons, are reviewed by the QRT for appropriateness. Inappropriate actions or failure to take action will be referred to DBHDS technical assistance staff to address with the offender. DBHDS technical assistance staff will contact CSBs demonstrating significant problems complying with the intent of these assurances. Another possible action is for DMAS to target agencies with deficiencies for Quality Management Reviews (QMRs).

DMAS QMR staff who identify problems with VIDES through record reviews will require the case management provider to submit and follow a corrective action plan. Serious violations (such as missing VIDES) may be referred to DMAS' Provider Integrity unit for payment retraction.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ● **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Once the case manager has determined that the individual meets functional and diagnostic criteria for the waiver (i.e., confirmed by the VIDES and the appropriate developmental disability diagnostic evaluation, he or she:

1. Offers the individual (and legal guardian or family member/caregiver, as applicable) the choice of Community Living Waiver or ICF/IID services. At this same juncture, the case manager informs the individual of the full array of services offered in this waiver for which he or she is eligible (including both consumer and agency-directed services). The case manager documents the individual's choice of waiver services or institutional care, as well as the review of all waiver services by obtaining signatures on the "Documentation of Individual Choice between Institutional Care or Home and Community-Based Services" form (DMAS 459-C).

If the individual (and family member/caregiver, as applicable) selects Community Living Waiver, confirmation of the completion of the "Documentation of Individual Choice between Institutional Care or Home and Community-Based Services" form is submitted to DBHDS for enrollment or placement on the statewide waiting list via the waiver management system. If the individual (and family member/caregiver, as applicable) selects ICF/IID placement, the case manager assists the individual with this option.

2. Once a slot has been identified for the individual and he or she has been enrolled into the waiver, the case manager meets with the individual (and family/caregiver, as applicable), to determine the individual's needs and supports necessary to provide appropriate services to the individual. At this point, the case manager provides a list to the individual (and family/caregiver, as appropriate) of the names of all available service providers, arranges for visits or interviews with the providers, as desired, confirms that any interested provider has a current DMAS participation agreement to provide the desired service and then documents in writing the individual's choice of waiver providers on the "Virginia Informed Choice" form (DMAS 460). While individuals always have the option to change providers if desired, this form is only required to be completed again when new waiver services are initiated or when the individual is dissatisfied with the current provider and the issues cannot be resolved.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The "Documentation of Individual Choice between Institutional Care or Home and Community-Based Services" form is retained indefinitely by the case manager. These are maintained in the case managers' records/EHR.

The "Virginia Informed Choice" form (DMAS 460/459A) is retained for at least six years in the case manager's record for adults; forms are kept for children until 18 years of age plus six years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Language translation services are available through a contracted entity, providing interpretation services for 150 different languages. All forms are available in alternative formats upon request.

Virginia offers language line services to any prospective or current Medicaid participants. Applications for benefits ask what language is spoken so that staff at the Virginia Department of Social Services are aware this language line may be needed. In addition, applications for birth certificates to verify identity and citizenship as part of the application for Medicaid benefits, are available in Spanish from the Virginia Department of Health (VDH) at http://www.vdh.virginia.gov/vitalrecords. Further, VDH serves as the state clearinghouse for information on laws, policies, reports, training, conferences and other facets of linguistic services. Most of the training and services offered are available to providers serving Medicaid applicants and participants.

CSBs, the entities responsible for receiving waiver applications, enrolling individuals and communicating with individuals during the supports planning process are bound by a State Behavioral Health and Developmental Services Board policy which states:

"It is the policy of the Board that the Department, state facilities, and CSBs shall provide services to individuals in the public behavioral health and developmental services system in a manner that is sensitive to their beliefs, norms, values, traditions, customs, and language regardless of their racial, ethnic, or cultural backgrounds. Consistent with this policy, the Department, state facilities, and CSBs shall develop mechanisms to facilitate the involvement of the community and individuals receiving services in the design and implementation of culturally and linguistically appropriate behavioral health and developmental services."

See https://dbhds.virginia.gov/assets/doc/about/boards/BHDS/1023(SYS)-6-08-REVISED-JUNE-2014.pdffor the full policy statement. DBHDS has an Office of Cultural and Linguistic Competency, which works with the CSBs to provide technical support for the development of further resources for cultural and linguistic competency at a regional level.

DMAS also has a language access plan where individuals can request forms and guidance documents to be translated into the individual's preferred language. Information on DMAS's language access plan can be found here: https://coverva.dmas.virginia.gov/dmas-language-and-disability-access-plan/

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Group Day Services**		
Statutory Service	**Group Home Residential**		
Statutory Service	**Individual Supported Employment**		
Statutory Service	**Personal Assistance Services**		
Statutory Service	**Respite**		
Supports for Participant Direction	**Consumer-Directed Services Facilitation (until 5/31/27)**		
Other Service	**Assistive Technology**		
Other Service	**Benefits Planning**		
Other Service	**Center-based Crisis Supports**		
Other Service	**Community Coaching**		
Other Service	**Community Engagement**		
Other Service	**Community Guide**		
Other Service	**Community-Based Crisis Supports**		
Other Service	**Companion Services**		
Other Service	**Crisis Support Services**		
Other Service	**Electronic Home-Based Services**		
Other Service	**Employment and community transportation**		
Other Service	**Environmental Modifications**		

Service Type	Service		
Other Service	Group Supported Employment		
Other Service	In-home Support Services		
Other Service	Peer Mentor Supports		
Other Service	Personal Emergency Response System		
Other Service	Private Duty Nursing		
Other Service	Shared Living		
Other Service	Skilled Nursing		
Other Service	Sponsored Residential		
Other Service	Supported Living		
Other Service	Therapeutic Consultation		
Other Service	Transition Services		
Other Service	Workplace Assistance Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Group Day Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Group Day Services include skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, career planning, and adaptive skills. They provide opportunities for peer interactions, community integration, and enhancement of social networks. Supports may be provided to ensure an individual's health and safety. Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case group day may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Other than supports agreed upon in the Plan for Supports to be delivered

via telehealth, these services take place in non-residential settings, separate from the individual's home. Group Day Services should be coordinated with any physical, occupational, behavioral, or speech/language therapies listed in the person-centered plan.

The allowable group day services include, but are not limited to:

a. Developing problem-solving, sensory, gross and fine motor, communication and personal care skills;

b. Developing self, social, and environmental awareness skills;

c. Developing skills as needed in positive behavior, using community resources, community safety and positive peer interactions, volunteering and participating in educational programs in integrated settings, forming community connections or relationships;

d. Supporting older adults in participating in meaningful retirement activities in their communities, i.e., clubs and hobbies;

e. Career planning and resume developing based on career goals, personal interests, and community experiences;

f. Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;

g. Providing safety supports in a variety of community settings.

h. Staff coverage for transportation of the individual between service activity sites; Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of waiver billing. The provider may not also bill mileage.

i. Personal care types of activities (i.e., assistance with ADLs) are included as an allowable activity in this service.

Identified activities that are permitted to be performed in either a face-to-face or via a HIPAA-compliant telehealth platform are:
a. Developing problem-solving, sensory, gross and fine motor, communication and personal care skills, and
b. Career planning and resume developing based on career goals, personal interests, and community experiences.

Group day services shall be coordinated with the therapeutic consultation plan, as applicable.

There is a small cohort of individuals for whom customized rates will be necessary.

INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:
Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs fall outside of the supports that are available and funded through the standard rate for their assigned reimbursement tier. These individuals have exceptional medical and/or behavioral support needs and require 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them. These individuals may require higher level supports in order to avoid placement in a state operated mental health or DD facility, or in a more restrictive environment. They are often identified as those who require greater support in order to find in-state providers willing to serve them.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports. In addition, these individuals may require the supervision and oversight required by more experienced/highly trained direct support staff or require clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.

Medically, an individual may require 1:1 or 2:1 staff support when they have a health history or recent health complication

that puts them at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during mealtime due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that they may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff may be necessary during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

Not all Group Day allowable activities easily translate to a telehealth model. The following allowable activities are ones that may be applicable and may be incorporated into revised Plan For Supports depending on individuals' specific needs and desired outcomes to be conducted in either a face-to-face or HIPAA-compliant telehealth modality. Providers will only be permitted to perform the allowable activities for the service billed through telehealth that are appropriate, as defined by the state Medicaid office (DMAS).

- Developing skills as needed in positive behavior, using community resources, community safety and positive peer interactions, forming community connections or relationships.
- Developing problem-solving abilities, sensory, gross and fine motor control abilities, and communication and personal care skills.
- Monitoring the individual's health, emotional, and physical condition.
- Supporting older adults in participating in meaningful alternative day activities in their communities.
- Providing safety supports.
- Career planning and resume developing based on career goals, personal interests, and community experiences.
- Telehealth delivery for group day will be limited to groups of three individuals or less and authorization for virtual services shall be limited to 20 hours per week.
- The group day service should not disrupt the lives of others in the residence nor unnecessarily intrude upon their privacy.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery; however, no more than 10% of the hours may be performed doing the identified allowable activities via telehealth. Any individual who uses telehealth for this service shall have his/her privacy respected while skill building of ADLs is being performed. The provider will take all necessary precautions to ensure the privacy and dignity of the individual are protected when supporting the individual in the development of personal care skills. In any instance where personal care skills are being provided via telehealth, it should be noted clearly in the service plan and communicated to the person and/or his/her substitute decision maker that they understand what is involved in telehealth delivery. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The service unit is an hour.

Support ratios should be based on the activity and the individual's needs as determined by the person-centered plan and limited to a ratio of no more than 7 individuals supported by 1 staff person.

Group Day Services occur one or more hours per day on a regularly scheduled basis for one or more days per week. Group day services, alone or in combination with Community Engagement, Community Coaching, Workplace Assistance, and/or Supported Employment services are limited to no more than 66 hours per week.

Medicaid will not pay for the cost of meals as part of this service.

When both the individual and the Group Day provider (as agreed upon by all parties) are utilizing telehealth platforms, the utilization of telehealth shall not exceed 10% of the authorized and billed units per month.

Individuals who are receiving this service under a Customized Rate may, due to extraordinary behavioral needs or medical needs as listed under the Service Definition, be found ineligible from receiving identified activities via a telehealth platform due to their direct, frequent, and intensive 1:1 or 2:1 staffing needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group Day Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Group Day Services

Provider Category:

Agency

Provider Type:

Group Day Services Provider

Provider Qualifications

License *(specify):*

Group day service providers must be licensed by DBHDS as a provider of
- center-based day support services OR
- non-center-based day support services

Certificate *(specify):*

Other Standard *(specify):*

Group day services providers must have a signed Provider Participation agreement with DMAS in order to provide these services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for reimbursement.

Providers must also assure that persons providing group day services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing Community Living Waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of group day services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced and announced onsite and desk reviews of licensed providers and each of its services at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of day support providers annually. Staff may conduct announced and unannounced onsite reviews or desk audits of the records at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Group Home Residential

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

These services shall consist of skill-building, routine supports, general supports, and safety supports, provided primarily 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.

Group Residential services shall be authorized for Medicaid reimbursement in the person-centered plan 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.

Group home residential services to the individual in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home or (ii) in the home of an adult foster care provider. In either setting, the provider must comply with the Americans with Disabilities Act and provide a homelike environment for the residents. Full compliance with the HCBS Settings Regulations is expected of all providers by 3/17/2022.

Residential Support includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

The allowable activities include, but are not limited to:

1) Skill-building related to personal care activities (toileting, bathing, and grooming; dressing; eating; mobility; communication; household chores; food preparation; money management; shopping, etc.);

2) Skill-building related to the use of community resources (transportation, shopping, dining at restaurants, participating in social and recreational activities, etc.);

3) Supporting the individual in developing the ability to replace challenging behavior with positive, accepted behavior for home and community environments, for example (not all inclusive):

- Developing a circle of friends;

- Handling social encounters with others; or

- Redirecting challenging behavior.

4) Monitoring health and physical conditions and providing supports with medication or other medical needs;

5) Providing supports with personal care, ADLs, IADLs, and use of community resources, for example (not all-inclusive):

- Completing personal care or mealtime tasks when physically unable to do so; or

- Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the individual's health and welfare

6) Supporting with transportation to and from training sites and community resources;

7) Providing general supports as needed; and

8) Providing safety supports to ensure the individual's health and safety.

There is a small cohort of individuals for whom customized rates will be necessary.

INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:
Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs fall outside of the supports that are available and funded through the standard rate for their assigned reimbursement tier. These individuals have exceptional medical and/or behavioral support needs and require 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them. These individuals may require higher level supports in order to avoid placement in a state operated mental health or DD facility, or in a more restrictive environment. They are often identified as those who require greater support in order to find in-state providers willing to serve them.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports. In addition, these individuals may require

the supervision and oversight required by more experienced/highly trained direct support staff or require clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.

Medically, an individual may require 1:1 or 2:1 staff support when they have a health history or recent health complication that puts them at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during mealtime due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that they may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff may be necessary during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is a day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group Home Residential provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Group Home Residential

Provider Category:

Agency

Provider Type:

Group Home Residential provider

Provider Qualifications

License *(specify):*

Group home residential support providers for adults (age 18 years and older) must meet one of the following provider categories:

1. An agency licensed by DBHDS as a provider of DD group home residential services.

2. A provider approved by the local DSS as an adult foster care provider, using regulations promulgated by DSS.

Group home residential support providers for children (under age 18 years) must be an agency licensed by DBHDS with a DD Children's Group Home Residential Services License.

Certificate *(specify):*

Other Standard *(specify):*

Group home residential providers must have a signed provider participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers must also assure that persons providing residential services have received training in the characteristics of I/DD and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing Community Living waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of Group Home Residential services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced and announced onsite and desk reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Individual Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Individual Supported Employment services consist of one on one ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to work in an integrated setting. Supported employment may include assisting the individual to locate a job or develop a job on behalf of the individual. Supported employment is conducted in a variety of settings where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals, including supports and training.
Personal assistance is not a part of individual supported employment.

Supported employment services include ongoing supports to obtain and maintain a job in competitive, customized employment, or self employment (including home-based self employment) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

The allowable activities include:

1. Vocational/job-related discovery or assessment;

2. Person-centered employment planning which results in employment related outcomes;

3. Individualized job development, with or without the individual present, that produces an appropriate job match for the individual and the employer to include job analysis and/or job carving;

4. Negotiation with prospective employers;

5. On-the-job training in work skills required to perform the job;

6. Ongoing evaluation, supervision, and monitoring of the individual's performance on the job but which do not include supervisory activities rendered as a normal part of the business setting;

7. Ongoing support services necessary to assure job retention;

8. Supports to ensure the individual's health and safety;

9. Development of work-related skills essential to obtaining and retaining employment, such as the effective use of community resources and break/lunch areas and transportation systems; and

10. Staff coverage for transportation between the individual's place of residence and the workplace when other forms of transportation are unavailable or inaccessible (i.e., time spent transporting).

The following identified activities may be performed in either a face-to-face or via a HIPAA-compliant telehealth platform where the ISP clearly defines the elements to be delivered via telehealth:

1. Elements of job-related discovery;

2. Employment planning;

3. Individualized job development;

4. Employment negotiation;

5. Job training;

6. Job retention; and

7. Development of work-related skills.

The individual's assessment and individual support plan must clearly reflect the individual's need for employment-related skill building.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery; however, no more than 10% of the available service hours may be conducted via telehealth and only the activities as listed above may be done through telehealth. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The service unit for individual supported employment is an hour, not to exceed 40 hours per week. Supported employment, alone or in combination with Community Engagement, Community Coaching, Workplace Assistance, and/or Group day services are limited to no more than 66 hours per week.

Providers for persons eligible for or receiving supported employment services funded under § 110 of the Rehabilitation Act of 1973 (through DARS) or §§ 602(16)(17) of the Individuals with Disabilities Education Act (IDEA) (through special education services) cannot receive payment for this service through Community Living waiver services. The case manager must assure that supported employment services are not available through these sources and document the finding in the individual's case management record. When services are provided through these sources, the individual support plan will not include them as a requested waiver service.

When both the individual and the Supported Employment Provider (as agreed upon by all parties) are utilizing telehealth platforms, the utilization of telehealth shall not exceed 10% of the authorized and billed units per month.

FFP is not available for any activities with incentive payments, subsidies, or unrelated vocational training expenses.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Individual Supported Employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Individual Supported Employment

Provider Category:
Agency

Provider Type:
Individual Supported Employment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers shall be DARS-contracted providers of supported employment services.
Supported employment providers must have a signed provider participation agreement with DMAS in order to provide supported employment services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Verification of Provider Qualifications

Entity Responsible for Verification:
DARS verifies that these providers meet criteria to be providers through a DARS-recognized accreditation body.

Frequency of Verification:
The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of supported employment providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Assistance Services

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Personal assistance services mean direct support with activities of daily living, instrumental activities of daily living, 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. These 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.

Each individual and family/caregiver, 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.

Allowable activities include:

1. Support with activities of daily living (ADLs), such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.;
2. Support with monitoring health status and physical condition;
3. Support with medication and other medical needs;
4. Supporting the individual with preparation and eating of meals;
5. Support with housekeeping activities, such as bed making, dusting, and vacuuming, laundry, grocery shopping, etc.;
6. Support to assure the safety of the individual;
7. Support needed by the individual to participate in social, recreational and community activities;
8. Assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when properly trained and supervised by an RN;
9. Accompanying the individual to appointments or meetings.

The personal assistant may help prepare and accompany the individual to work or post-secondary school and assist him or her with ADLs while the individual is at work or school and upon return home. DBHDS will review the individual's needs when determining the services that will be provided to the individual in the workplace or school. The assistant may not perform any functions related to the individual completing his or her job or school functions or for supervision time during work or school.

Individuals are afforded the opportunity to act as the employer in the consumer-direction of personal assistance services for the waiver. This involves hiring, training, supervision, and termination of consumer-directed supports assistants. Individuals choosing to receive services through the consumer-directed model may do so by choosing a services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) to provide the training and guidance needed to be an employer. If the individual is unable to independently manage his/her own consumer-directed services, a family member/caregiver or other chosen person must serve as the employer of record (EOR) on behalf of the individual.

The services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) coordinates support activities for those individuals electing consumer-direction of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is an hour. Personal assistance hours are limited to 56 hours per week, 52 weeks per year, for a maximum total of 2,920 hours per year. The Department shall provide for individual exceptions to this limit using criteria

based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provide.

Personal assistance shall not include either practical or professional nursing services. This service shall not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to nurse delegation rules in the state Code.

Personal assistance shall not be available to individuals who
(i) receive residential services in a group home, sponsored residential home or who live in assisted living facilities, except personal assistance delivered in the work or postsecondary school-related setting, or
(ii) receive comparable services provided through another program or service.

The services under the Community Living Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Work personal assistance or postsecondary school-related personal assistance shall not be provided if they should be provided by DARS or under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act (42 USC § 12101 et seq.), the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia), or § 504 of the Rehabilitation Act (42 USC § 701 et seq.).

When a legally responsible individual is paid to provide personal assistance, the legally responsible individual is limited to provide 40 hours per week of paid personal assistance.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Service Provider (Agency-Directed)
Individual	Consumer-Directed Personal Assistant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Assistance Services

Provider Category:
Agency

Provider Type:
Personal Assistance Service Provider (Agency-Directed)

Provider Qualifications

License *(specify):*

The following types of providers can deliver personal assistance services:

1. Providers licensed by DBHDS as a provider of DD group home, DD supervised residential, or DD supportive in-home

residential services.

OR

2. Personal care agencies licensed by the Virginia Department of Health or that have accreditation from any organization recognized by the CMS for the purposes of Medicare certification.

Licensing requirements for RNs and LPNs are outlined in Chapter 30 of title 54.1 of the Code of Virginia.

Certificate *(specify):*

Other Standard *(specify):*

Personal assistance providers must have a signed provider participation agreement with DMAS in order to provide personal assistance services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers licensed by DBHDS as a provider of DD group home, DD supervised residential, or DD supportive in-home residential services must employ a program (residential services) supervisor who will provide ongoing supervision of all personal assistants and conduct the initial assessment and subsequent reassessments.

Personal care providers who are licensed by the Virginia Department of Health or have an accreditation from an organization recognized by CMS for the purposes of Medicare certification must:

a. Employ or subcontract with and directly supervise a RN or a LPN who will provide ongoing supervision of all personal assistants. RNs must conduct the initial assessment and subsequent reassessments;
b. The supervising RN or LPN must be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience which may include work in an acute care hospital, public health clinic, home health agency, ICF/IID or nursing facility;
c. Employ and directly supervise personal assistants who will provide direct support to individuals. Each assistant hired by the provider shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS. Each assistant must:
1) Be at least 18 years of age;
2) Be able to read and write English to the degree necessary to perform the tasks expected;
3) Complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider agency must obtain documentation that the assistant has satisfactorily completed this training program. DMAS requirements may be met in one of three ways:
a) Registration as a certified nurse aide;
b) Graduation from an approved educational curriculum which offers certificates qualifying the student as a nursing assistant, geriatric assistant, or home health aide; or
c) Completion of provider-offered training, which is subject to approval from DMAS.
4) Be physically able to do the work;
5) receive a tuberculosis screening according to the requirements of the Virginia Department of Health; and
6) Have a satisfactory work record, as evidenced by two references from prior job experiences (if applicable), including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children.

Providers must also assure that persons providing personal assistance services have received training in the characteristics of DD and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services is responsible for the verification of personal care agency provider qualifications.

DBHDS Office of Licensing verifies that providers of DBHDS licensed DD group home, DD supervised residential or DD supportive residential services meet DBHDS licensing standards.

VDH verifies that VDH licensed agencies meet VDH standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced and announced onsite and desk reviews of DBHDS licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of personal assistance providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Assistance Services

Provider Category:

Individual

Provider Type:

Consumer-Directed Personal Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

For consumer-directed personal assistance services (CD-PA) individuals will hire their own personal assistants and manage and supervise the assistant's performance. If an individual is unable to direct his or her own services, an adult family member/caregiver or other chosen person may act on behalf of the individual as the employer of record for the assistant.

Personal assistants do not need to be enrolled with DMAS (i.e., have a participation agreement) to provide consumer-directed PA services.

Personal assistant qualifications include the following requirements. The assistants must:

a. Be 18 years of age or older and possess a valid Social Security number that has been issued by the Social Security Administration to the person who is to function as the assistant;
b. Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;
c. Have the required skills and physical abilities to perform the services as specified in the individual's Plan for Supports;
d. Be willing to attend training at the individual's and the family/caregiver's, and EOR's, as appropriate, request;
e. Understand and agree to comply with the DMAS' requirements; and
f. Receive a tuberculosis screening according to Virginia Department of Health guidelines.

The CD Personal Assistant must submit to a criminal history record checks for barrier crimes, as defined in 12VAC30-120-1000, within 15 days from the date of employment. If the individual to be served is a minor child, consent to a search of the VDSS Child Protective Services Central Registry.

The assistant will not be compensated for services provided to the individual subsequent to the receipt of a records check verifying that the assistant has been convicted of crimes described in the Code of Virginia, §37.2-314, Subsection B, or if the assistant has a founded complaint confirmed by the DSS Child Protective Services Central Registry.

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual/employer of record is responsible for the verification of
- the employee's skill set,
- the employee's willingness to attend training upon request,
- possession of basic math, reading & writing skills,
- compliance with waiver requirements, and
- receipt of verification of a TB screening according to Virginia Department of Health guidelines.

The Fiscal Management Service (FMS) is responsible for verifying that
- the employee meets the minimum age requirement,
- the employee possesses a valid SSN,
- the criminal records check/CPS registry check has been completed.

Frequency of Verification:

Initially upon hire.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. Respite is allowed in a family home, a respite center, a sponsored residential home, or in a group home for an individual who lives with his family but is receiving respite in that group home setting. It is not allowed in a group home for a resident of that group home, an ICF/IID, or a nursing home. Services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary

caregiver. 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.

The allowable activities include:
1) Support with activities of daily living such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.;
2) Support with monitoring health status and physical condition;
3) Support with medication;
4) Support with medical needs;
5) Support with preparation and eating of meals;
6) Support with housekeeping activities, such as bed-making, dusting and vacuuming, laundry, grocery shopping, etc.;
7) Support to ensure the safety of the individual;
8) Support needed by the individual to participate in social, recreational, or community activities;
9) Assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when properly trained and supervised by an RN;
10) Accompanying the individual to appointments or meetings.

Individuals are afforded the opportunity to act as the employer in the consumer-direction of respite services. This involves hiring, training, supervision, and termination of consumer-directed supports assistants. Individuals choosing to receive services through the consumer-directed model may do so by choosing a services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) to provide the training and guidance needed to be an employer. If the individual is unable to independently manage his/her own consumer-directed services, or if the individual is under 18 years of age, he/she must an adult family member/caregiver or other chosen person serve as the employer of record (EOR) on behalf of the individual.

The services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) coordinates support activities for those individuals electing consumer-direction of services.

FFP is not claimed for the cost of room and board.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite is limited to 480 hours per individual per year.

Respite assistance shall not include either practical or professional nursing services or those practices regulated in the Nurse Practice Act. This service shall not include skilled nursing services with the exception of skilled nursing tasks that may be delegated.

Individuals who receive personal assistance from a legally responsible individual (spouse or parent of the minor waiver individual) shall not be authorized for the respite service, since the legally responsible individual, as primary caregiver, is paid.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer-Directed Respite Assistant
Agency	Respite Service Provider (Agency-Directed)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Consumer-Directed Respite Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Respite assistants do not need to be enrolled with DMAS (i.e., have a participation agreement) to provide consumer-directed respite services.

Respite assistant qualifications include the following requirements. The assistants must:

a. Be 18 years of age or older and possess a valid Social Security number that has been issued by the Social Security Administration to the person who is to function as the assistant;
b. Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;
c. Have the required skills and physical abilities to perform the services as specified in the individual's Plan for Supports;
d. Be willing to attend training at the individual's and the family/caregiver's, and EOR's, as appropriate, request;
e. Understand and agree to comply with the DMAS' requirements; and
f. Receive a tuberculosis screening according to Virginia Department of Health guidelines.

The CD respite assistant must submit to a criminal history record checks for barrier crimes, as defined in 12 VAC 30-120-1000, within 15 days from the date of employment. If the individual to be served is a minor child, consent to a search of the VDSS Child Protective Services Central Registry.

The assistant will not be compensated for services provided to the individual subsequent to the receipt of a records check verifying that the assistant has been convicted of crimes described in the Code of Virginia, §37.2-314, Subsection B, or if the assistant has a founded complaint confirmed by the DSS Child Protective Services Central Registry.

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual/employer of record is responsible for the verification of
- the employee's skill set,
- the employee's willingness to attend training upon request,
- possession of basic math, reading & writing skills,
- compliance with waiver requirements, and
- receipt of verification of a TB screening according to Virginia Department of Health guidelines.

The Fiscal Management Service is responsible for verifying that

- the employee meets the minimum age requirement,
- the employee possesses a valid SSN,
- the criminal records check/CPS registry check is completed.

Frequency of Verification:

Initially upon hire.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Respite Service Provider (Agency-Directed)

Provider Qualifications

License *(specify):*

Any of the following types of providers can provide respite services:

1. A provider licensed by DBHDS as a provider of:

a. DD Supportive in-home services, which may provide respite services based in and from the individual's home;

b. DD Center-based respite services, which may provide respite services based in and from the approved respite center (licensed facility);

e. DD Residential respite services, which may provide respite services based in and from the currently licensed group home or sponsored residential home, as long as DBHDS Office of Licensing approves the residential respite services.

2. A provider approved by DSS as a foster care home for children, which may provide respite services based from the provider's home to children not currently residing in the home only;

3. A provider approved by DSS as an adult foster care home, which may provide respite services based from the provider's home to adults not currently residing in the home only; or

4. Personal care agencies licensed by the Virginia Department of Health or that have accreditation from any organization recognized by the CMS for the purposes of Medicare certification which may provide respite services based in and from the home of the individual.

Licensing requirements for RNs and LPNs are outlined in Chapter 30 of title 54.1 of the Code of Virginia.

Certificate *(specify):*

Other Standard *(specify):*

Respite providers must have a signed provider participation agreement with DMAS in order to provide respite services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Providers that have a personal care/respite care provider participation agreement with DMAS may provide respite under that agreement.

Individuals employed by a personal care agency licensed by VDH (i.e.,other than DBHDS licensed or DSS approved providers) who provide respite must meet the requirements of DMAS personal/respite assistant. Basic qualifications for respite assistants include:

* Physical ability to do the work;
* Ability to read and write English to the degree necessary to perform the tasks expected; and
* Completion of a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

1) Registration as a certified nurse aide;
2) Graduation from an approved educational curriculum which offers certificates qualifying the student as a nursing

assistant, geriatric assistant, or home health aide; or
3) Completion of provider-offered training.

Assistants shall have a satisfactory work record, as evidenced by two references from prior job experiences, if applicable, including no evidence of possible abuse, neglect, and exploitation of elderly persons, children, or adults with disabilities.

Providers shall ensure that staff providing respite services meet provider training and competency requirements.

If the provider is licensed by VDH, the respite provider must employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all respite assistants:

1) The RN or LPN must be currently licensed to practice in the Commonwealth or hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice nursing and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

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

If the provider is a DBHDS-licensed or DSS-approved provider, a (residential) supervisor will provide ongoing supervision of all respite assistants.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that DBHDS-licensed providers of respite services meet DBHDS licensing standards.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced and announced onsite and desk reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of respite providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Consumer-Directed Services Facilitation (until 5/31/27)

HCBS Taxonomy:

Category 1: 12 Services Supporting Self-Direction

Sub-Category 1: 12020 information and assistance in support of self-directio

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Services facilitation (until 5/31/27) assists the individual or the individual's family/caregiver, or Employer of Record (EOR), as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery.

The services facilitator (until 5/31/27) is responsible for supporting the individual or the individual's family/caregiver, or EOR, as appropriate, by collaborating with the case manager to ensure the development and monitoring of the CD services plan for supports, providing employer management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

The SF (until 5/31/27) is responsible for conducting an initial comprehensive visit during which an assessment of the individual's particular needs for a requested consumer-directed service is completed. This is followed by assisting in the development of the support plan for consumer-directed services. The services facilitator (until 5/31/27) provides "employer management training" to the individual or EOR, as appropriate, to educate him on his responsibilities as an employer. This includes training on advertising for, screening, hiring, retaining and firing an employee, as well as how to complete the necessary employment-related paperwork regarding taxes, criminal background checks, etc. and must be completed before the CD employee is hired.

Once the individual has hired a CD employee, the SF (until 5/31/27) may assist the individual with securing needed training for the employee. The SF (until 5/31/27) is required to make "routine on-site" visits periodically to monitor and ensure the quality and appropriateness of the services being provided. In addition, the SF (until 5/31/27) should be available to the individual by telephone during business hours and attend meetings, as requested by the individual. Annually, the SF (until 5/31/27) conducts an update (or reassessment) visit to review the individual's current status as related to CD services and develop a new annual support plan.

Services facilitators (until 5/31/27) are required to make, at a minimum, four in-person visits to the individual. The use of telehealth within this service is exclusively between the Employer of Record (EOR) and Services Facilitator (until 5/31/27) on the EOR's ability to perform their functions as an employer satisfactorily. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation

immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services facilitation (until 5/31/27) is 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.

The SF (until 5/31/27) must make an initial comprehensive home visit to collaborate with the individual and family/caregiver as appropriate in the development of the ISP. This may be done only once for consumer-directed services. Subsequent visits, or the start of a new SF (until 5/31/27), are handled as update (or reassessment) visits, which are generally shorter in duration and reimbursed at a lower level, as the initial information has already been gathered from the individual and should be available.

The "employer management training" occurs only once at the initiation of CD services. If additional training is required for the individual, EOR or employee, this is billed under management training which is limited to up to four visits per six month period. Management Training visits, but not the Employer Management Training, may be delivered through either a face-to-face or via a HIPAA-compliant telehealth method.

At least one face-to-face meeting with the individual is required at least every three months to reassess needs and ensure appropriateness of services. During these routine visits with the individual, the services facilitator (until 5/31/27) 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. These are billed as "routine on-site" visits. A face-to-face reassessment visit must occur every six months in which the SF (until 5/31/27) works with the individual/family to review and to revise the Plan of Care based on the assessed needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Services Facilitation Provider (until 5/31/27)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Consumer-Directed Services Facilitation (until 5/31/27)

Provider Category:

Agency

Provider Type:

Services Facilitation Provider (until 5/31/27)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Services facilitation (until 5/31/27) providers must have a signed provider participation agreement with DMAS in order to provide services facilitation (until 5/31/27) services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

To be enrolled as a Medicaid CD services facilitator (until 5/31/27) and maintain provider status, the services facilitator (until 5/31/27) shall have sufficient resources to perform the required activities, including the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. To be enrolled, the services facilitator (until 5/31/27) shall also meet the combination of work experience and pass the required Services Facilitation (until 5/31/27) modules with at least 80% passing score every five years that indicate the possession of the specific knowledge, skills, and abilities as set out in DMAS' guidance documents to perform this function.

The Medicaid reimbursed CD services facilitator (until 5/31/27) shall not be the individual enrolled in the waiver, 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services verifies provider qualifications.

Frequency of Verification:

The Virginia Department of Medical Assistance Services verifies provider qualifications initially and subsequently every two years.

DMAS QMR staff review a sample of services facilitation (until 5/31/27) providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living (ADLs), or to perceive, control, or communicate with the environment in which they live, or which are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.

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.

Equipment or supplies already covered by the State Plan may not be purchased under the waiver. The case manager is required to ascertain whether an item is covered through the State Plan before requesting it through the waiver.

Assistive technology items must be recommended and determined appropriate to meet the individuals needs by the applicable professional (e.g., physical therapist, occupational therapist, speech and language therapist), prior to preauthorization of the service.

The equipment and activities include:

1. Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the State Plan for Medical Assistance;

2. Durable or non-durable medical equipment and supplies not available under the State Plan for Medical Assistance;

3. Adaptive devices, appliances, and controls not available under the State Plan for Medical Assistance which enable an individual to be more independent in areas of personal care and ADLs; and

4. Equipment and devices not available under the State Plan for Medical Assistance, which enable an individual to communicate more effectively.

The case manager submits service plan information to the operating agency, DBHDS, for service authorization. DBHDS employs Qualified Developmental Disability Professionals (QDDPs) to complete the approval/service authorization process. DMAS reviews a sample of DBHDS service authorizations as part of its monitoring process.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum Medicaid-funded expenditure for assistive technology and Electronic Home-Based Services is $10,000 per service plan year. An individual, based on their needs, may allocate a portion or all of the service plan year cap towards one or a combination of the two services.

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.

Assurance: The services under the Community Living Waiver, VA.0372.R04.00, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Assistive technology shall be provided by DMAS-enrolled durable medical equipment (DME) providers or DMAS-enrolled CSBs with a DMAS provider agreement to provide AT. Providers may also go through the CSBs' OHCDS as a provider.

DMAS contracts directly with durable medical equipment providers, which routinely provide specialized medical equipment and supplies in accordance with the Virginia State Plan for Medical Assistance. Equipment or supplies not covered by the State Plan may be purchased under Assistive Technology.

A rehabilitation engineer or certified rehabilitation specialist (CRS) may be utilized if, for example:

- The assistive technology will be initiated in combination with environmental modifications involving systems which are not designed to go together; or

- An existing device must be modified or a specialized device must be designed and fabricated.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of assistive technology providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Benefits Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Benefits planning is an individualized analysis and consultation service provided to assist individuals receiving waiver services and social security benefits (SSI, SSDI, SSI/SSDI) to understand their benefits and explore the possibility of work, to start work, and the effect of work on local, state, and federal benefits. This service includes education and analysis about current benefits status and implementation and management of state and federal work incentives as appropriate.

This service results in the development of guidance and documents to assist individuals and their families/legal representatives to overcome fear and ambivalence about losing necessary supports and benefits if they choose to work or stay on the job. This service enables individuals to make an informed choice about the initiation of work. This service also provides assistance, education, and training to working individuals to make successful transition to financial independence.

Allowable Activities
Each of the allowable activities are available dependent upon the individual meeting criteria for receipt of the service activity. Elements of the allowable activities that involve interactions with the individual and/or representative may be conducted in person or via telehealth platforms (as appropriate) and include the following:

1. Pre-employment Benefits Review which may include:

•Benefits Planning Query (BPQY from SSA)
Description: A BPQY provides information about an individual's disability cash benefits, health insurance, scheduled continuing disability reviews, representative payee, and work history, as stored in SSA's electronic records. The BPQY is an important planning tool for the individual or other person who may be developing customized services for an individual who wants to start working or stay on the job.

•Pre-employment Benefits Summary and Analysis (BS&A)
Description: Work with the individual to develop a benefits analysis and net income analysis report with both a current situation and at least two other potential situations involving Social Security work incentives.

•Employment Change Benefits Summary and Analysis
Description: Work with the individual when he experiences a change in employment situation to develop a benefits analysis and net income analysis report with both a "current situation" and at least two other potential situations involving Social Security work incentives.

2. Work Incentives Development or Revisions (PASS, IRWE, BWE, IDA): Work with the individual and family/legal representative to develop:

•Plan to Achieve Self-Support (PASS):
(Part 1)
Description: Develop, in collaboration with the individual and provider, a Plan to Achieve Self-Support (PASS) and ensure that it is submitted to the Social Security Administration (SSA).

(Part 2)
Description: Ensure the approval of the PASS plan from the SSA PASS CADRE through modifications or other appropriate services.

•Impairment Related Work Expenses (IRWE):
Description: IRWEs reduce the amount of income that Social Security counts against an individual's benefits by deducting the amount of an expense from their total countable wages. In order to qualify for the IRWE, the expense must be related to the individual's disability, work, and be an expense without which he cannot work. This service involves working with the individual to develop and submit appropriate forms and supporting documents to SSA, as needed, to successfully obtain the IRWE work incentive.

•Blind Work Expenses (BWE):
Description: Work with an individual confirmed to be blind to develop and submit appropriate forms and supporting documents to SSA, as needed, to successfully obtain the BWE work incentive, which is that SSI will not count any earned income when the primary diagnosis is blindness when the expense is reasonably attributed to earning the income, i.e., guide dog, transportation to and from work, etc.

•Individual Development Accounts (IDA):
Description: Work with the individual to develop matched savings accounts to assist him in saving towards the purchase of a lifelong asset such as a home.

•Student Earned Income Exclusion (SEIE):
Description: Work with the individual to develop and submit appropriate documents to SSA to receive benefits under the SEIE work incentive. Student earned income exclusion allows individuals under the age of 22 who regularly attend school or are involved in a vocational education program to exclude earned income up to a certain amount per a month.

•Medicaid While Working - Section 1619(b)
Description: Work with the individual to develop and submit an appropriate letter and supporting documents to SSA and the Virginia Department of Social Services (VDSS), and Medicaid, as needed, to receive benefits under 1619(b), provides for the continuation of Medicaid when a beneficiary loses his SSI due to earning wages above the SSI threshold.

•Medicaid Works (Virginia's Medicaid Buy-In Program)
Description: Work with the individual who is currently eligible for and/or receiving Medicaid to complete and submit the MEDICAID WORKS agreement and supporting documents to the Virginia Department of Social Services (VDSS), as needed, to enroll in the Medicaid Buy-In program (may include Medicaid application or updating the resource section of the Medicaid application). This enables workers with disabilities to earn higher income and retain more in savings or resources than is usually allowed by Medicaid.

•Work Incentive Revisions
Description: Work with the individual to revise one of the work incentives plans above as determined needed by a significant change in status.

3. Resolution of SSA benefits issues (e.g., Overpayments, Subsidies, Student Earned Income Exclusion, Medicaid While Working)

• Overpayments:
Description: Work with the individual to address Social Security overpayments that arise.

• Subsidies:
Description: Work with the individual to develop and submit appropriate documents to SSA to receive the Subsidy work incentive.

•Work Activity Reports:
Description: Assist the individual family/legal representative in filling out and returning forms to SSA.

4. Other Services
• ABLEnow
Description: Work with the individual and family, if applicable, to open an ABLEnow account.

• Financial Health Assessment
Description: The Financial Health Assessment (FHA) is a tool used to gauge an individual's understanding of his current financial situation.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities in a lower stress environment for the individual. The activities allowed to be performed via telehealth are meant to assist the individual in understanding about and resolving issues with his/her benefits so that the individual can pursue his/her personal goals towards greater community engagement and integration. Actual community engagement does not occur within this service. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Receipt of this service shall not be tied to the receipt of any other covered waiver or Medicaid service. This service may be authorized one time per allowable activity per individual per calendar year. However, a service may be reauthorized within a calendar year if the individual's situation has changed in terms of disability conditions, benefit type, or employment status.

No vendor shall bill for waiver Benefits Planning services while the eligible individual has an open employment services case with DARS and is eligible for this through DARS.

The annual year limit for this service shall be $3,000. No unspent funds from one plan year shall be accumulated and carried over to subsequent plan years.

Plan for Achieving Self-Support-Part 1 7.0 hours
Plan for Achieving Self Support-Part 2 12.5 hours

Impairment Related Work Expense 9.0 hours
Blind Work Expense 9.0 hours
1619(b) Medicaid 4.5 hours
Student Earned Income Exclusion 9.0 hours
Subsidy 9.0 hours
Work Activity Reports 6.0 hours
Medicaid Works 5.5 hours
Overpayment 3.5 hours
Benefits Planning Query 1.0 hours
Pre-Employment BSA 7.0 hours
WorkWORLD Summary and Analysis 7.0 hours
Individual Development Accounts 7.0 hours
Section 301/Able Now 4.5 hours
Financial Health Assessment 3.5 hours
WI Revisions 7.0 hours

Allowable activities that can be performed using telehealth can be performed for up to 100% of the service hours.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:
Individual
Provider Type:

Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
1. An eligible provider for this service shall be one of the following:
a. A nationally certified Social Security Administration (SSA) Community Work Incentive Coordinators (CWIC); or
b. A Department for Aging and Rehabilitative Services (DARS) certified Work Incentive Specialist Advocate (WISA) approved vendor.

2. The Department for Aging and Rehabilitative Services (DARS) shall provide written verification for certified Work

Incentive Specialist Advocates (WISA). SSA certification shall be provided by Community Work Incentives Coordinators (CWIC).

Other Standard *(specify):*

Benefits Planning Services providers must have a signed Provider Participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Aging and Rehabilitative Services and Department of Medical Assistance Services ensure that providers meet the above qualifications.

Frequency of Verification:

DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews or desk audits of the records at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Center-based Crisis Supports

HCBS Taxonomy:

Category	Sub-Category
Category 1: 10 Other Mental Health and Behavioral Services	**Sub-Category 1:** 10030 crisis intervention
Category 2: 10 Other Mental Health and Behavioral Services	**Sub-Category 2:** 10070 psychosocial rehabilitation
Category 3: 10 Other Mental Health and Behavioral Services	**Sub-Category 3:** 10090 other mental health and behavioral services
Category 4: 11 Other Health and Therapeutic Services	**Sub-Category 4:** 11030 medication assessment and/or management

Service Definition *(Scope):*

Center-based Crisis Supports provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through utilization of assessments, close monitoring, and a therapeutic milieu. Services are provided through planned and emergency admissions. Planned admissions will be provided to individuals who are receiving ongoing crisis services

and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. Crisis stabilization admissions will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from experiencing stability within their home setting. All supports are individualized, follow person-centered service planning process, are meet HCBS regulations requirements (441.301(c)(4)(1) and 441.301(c)(4)(f).

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/IID placement;
(iii) immediate threat of loss of a community service due to a severe situational reaction; or
(iv) causing harm to self or others.

The allowable activities include but are not limited to:
1. Psychiatric, neuropsychiatry, and psychological assessment, and other assessments and stabilization techniques;

2. Medication management and monitoring;

3. Behavior assessment and positive behavior support;

4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;

5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community

6. Assisting with skill building in the Crisis Therapeutic Home as related to the behavior creating the crisis in areas such as self-care/ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, and medication compliance

Number 5 mentioned above provides training to those directly involved with the individual in his typical community environments (i.e., family home, group home, day services). Number 6 mentioned above is training (the Commonwealth typically uses the term "skill building") for the individual to enable him to expand his skill repertoire in order to prevent future crises.

7. Supervision of the individual in crisis to ensure his or her safety and that of others in the environment.

Center-based crisis supports is only provided to individuals age 21 and over. All medically necessary center-based crisis supports for children under age 21 are covered in the state plan pursuant to the EPSDT benefit."

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provision is limited to six months per year to be authorized in 30 day increments.

In accordance with the CMS Informational Bulletin issued on July 7, 2014, center-based crisis supports for individuals under age 21 shall be accessed through the state plan pursuant to ESPDT. Center-based crisis supports through this waiver shall not be available to individuals under age 21.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Center-based Crisis Supports Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Center-based Crisis Supports

Provider Category:

Agency

Provider Type:

Center-based Crisis Supports Provider

Provider Qualifications

License *(specify):*

Providers must be licensed by DBHDS as a provider of
- For Adults: Group home Service--REACH (Regional Education Assessment Crisis Services Habilitation)
- For Children: Residential Group Home--REACH

Certificate *(specify):*

Other Standard *(specify):*

Providers must have a signed provider participation agreement with DMAS in order to provide Center-based crisis services.The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Crisis intervention shall be provided by a Licensed Mental Health Professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP, a certified pre-screener, or QDDP. A DSP under the supervision of one of the aforementioned professionals may provide skill-building and supervising of the individual in crisis only.

The QDDP providing crisis intervention services must have:
1. At least one year of documented experience working directly with individuals who have developmental disabilities.
2. A bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; or a bachelor's degree in another field in addition to an advanced degree in a human services field; and
3. The required Virginia or national license, registration, or certification, as is applicable, in accordance with his or her profession.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of center-based crisis services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

DBHDS Office of Licensing staff conducts unannounced and announced onsite and desk reviews of DBHDS licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews

or desk audits of the records at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
04 Day Services	04020 day habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Coaching is a service designed for individuals who need one to one support in order build a specific skill or set of skills to address a particular barrier(s) preventing a person from participating in activities of Community Engagement.

Allowable activities:

Skill building through the implementation and participation in community activities and opportunities such as:

- Activities and public events in the community
- Community educational activities and events
- Utilization of public transportation

Skill building and support in positive behavior, relationship building and social skills. Elements of this activity may be provided via a HIPAA-compliant telehealth platform with sufficient justification/documentation contained in the ISP.

Support with self-management, eating, and personal care needs of the individual while in the community. Elements of this activity may be provided via a HIPAA-compliant telehealth platform with sufficient justification/documentation contained in the ISP.

Assuring the individual's safety through 1:1 supervision in a variety of community settings

Monitoring the individual's health and physical condition and providing supports with medication and other medical needs.

Providing routine supports and safety supports with transportation to and from community locations and resources.

For situations in which Community Coaching and/or Community Engagement are delivered via telehealth to individuals in their homes, a new Plan for Supports reflecting the new activities, the accompanying schedule, and a detailed method of service delivery must be submitted for service authorization. In all situations, the Plans for Supports must reflect those allowable activities that are conducted via telehealth. Additionally, documentation must reflect these new activities and the service delivery method, as well as the individual's willingness and ability to participate in telehealth supports and services. A Community Engagement or Community Coaching staff member would be expected to guide individuals through IT support, the development of online social skills, building relationship bridges through social exchanges, coordinating planning of resources and supplies, etc. The CE or CC provider would be expected to ensure that the individual agrees to receive the service(s) in that location and that the residential setting agrees to both allow the provider access and the schedule of services.

There is, however, a small cohort of individuals who are extremely medically fragile and/or behaviorally challenged for whom customized rates will be necessary.

INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:
Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs fall outside of the supports that are available and funded through the standard rate for their assigned reimbursement tier. These individuals have exceptional medical and/or behavioral support needs and require 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them. These individuals may require higher level supports in order to avoid placement in a state operated mental health or DD facility, or in a more restrictive environment. They are often identified as those who require greater support in order to find in-state providers willing to serve them.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports. In addition, these individuals may require the supervision and oversight required by more experienced/highly trained direct support staff or require clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.

Medically, an individual may require 1:1 or 2:1 staff support when they have a health history or recent health complication that puts them at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during mealtime due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that they may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff may be necessary during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery; however, no more than 10% of the available service hours may be conducted via telehealth and only the activities as listed above may be done through telehealth. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Only planning activities related to community engagement may be performed through telehealth in this service. Any actual community engagement must be performed in person in the community and not within the individual's residence or a licensed residential or day setting.

Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is an hour. Community Coaching services, alone or in combination with Community Engagement, Group Day, Workplace Assistance, and/or Supported Employment services are limited to no more than 66 hours per week.

When the individual and the Community Coaching provider (as agreed upon by all parties) are utilizing telehealth platforms, the utilization of telehealth shall not exceed 10% of the authorized and billed units per month.

The service is provided with a 1:1 ratio.

Individuals who are receiving this service under a Customized Rate, may, due to extraordinary behavioral needs or medical needs as listed under Service Definition, be found ineligible from receiving identified activities via a telehealth platform due to their direct, frequent, and intensive 1:1 or 2:1 staffing needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Coaching provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Coaching

Provider Category:

Agency

Provider Type:

Community Coaching provider

Provider Qualifications

License *(specify):*

Community coaching service providers must be licensed by DBHDS as a provider of non-center-based day support services.

Certificate *(specify):*

Other Standard *(specify):*

Providers must have a signed provider participation agreement with DMAS in order to provide these services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for reimbursement.

Providers must also assure that persons providing Community Coaching services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing Community Living Waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of Community Coaching services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced onsite reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of residential providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Engagement

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Community Engagement, as directed by the person and their person-centered plan, supports and fosters the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities. Community engagement provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). This service is delivered almost exclusively in community locations that are natural settings for the activities in which the individuals receiving this service are interesting in participating. All allowable activities for this service may not occur in "centers." The activities enhance the individual's involvement with the community and facilitate the development of natural supports. Community Engagement must be provided in the least restrictive and most integrated settings according to the individual's person-centered plan and individual choice.

Allowable Activities:

a. Skill building, education, support and monitoring that assists the individual with the acquisition and retention of skills in the following areas: (i) activities and public events in the community; (ii) community educational activities and events; (iii) interests and activities that encourage meaningful use of leisure time; (iv) volunteer experiences; (vi) maintaining contact with family and friends; and (vii) development of independence in activities of daily living.
b. Skill building and education in self-direction designed to enable the individual to achieve one or more of the following outcomes particularly through community collaborations and social connections developed by the provider (e.g., partnerships with community entities such as senior centers, arts councils, etc.): (i) development of self-advocacy skills; (ii) exercise of civil rights; (iii) acquisition of skills that promote the ability to exercise self-control and responsibility over services and supports received or needed; (iv) acquisition of skills that enable the individual to become more independent, integrated, or productive in the community; (v) development of communication skills and abilities; (vi) furthering spiritual practices; (vii) participation in cultural activities; (viii) developing skills that enhance career planning goals in the community; (ix) development of living skills; (x) promotion of health and wellness; (xi) development of orientation to the community, mobility, and the ability to achieve the desired destination; (xii) access to and utilization of public transportation; or (xiii) interaction with volunteers from the community in program activities.
c. Providing routine supports and safety supports with transportation to and from community locations and resources.

Exploring community-based interests and activities and gathering general information about said interests and activities in a one-to-one setting may be conducted via telehealth platforms. Since the COVID-19 pandemic, higher rates of use of telehealth have become standard across many elements of the healthcare and behavioral health practices. The addition of telehealth options to some Virginia Waiver services is not intended to supplant community integration, but rather to complement it. The ability for individuals to connect with providers via HIPAA compliant remote platforms offers the opportunity to prepare and/or plan for community integration opportunities in secure and lower stress environments. The services that serve a community integration purpose are not eligible for 100% telehealth delivery.

For situations in which Community Coaching and/or Community Engagement are delivered via telehealth to individuals in their homes, a new Plan for Supports reflecting the new activities, the accompanying schedule, and a detailed method of service delivery must be submitted for service authorization. In all situations, the Plans for Supports must reflect those allowable activities that are conducted via telehealth. Additionally, documentation must reflect these new activities and the service delivery method, as well as the individual's willingness and ability to participate in telehealth supports and services. A Community Engagement or Community Coaching staff member would be expected to guide individuals through IT support, the development of online social skills, building relationship bridges through social exchanges, coordinating planning of resources and supplies, etc. The CE or CC provider would be expected to ensure that the individual agrees to receive the service(s) in that location and that the residential setting agrees to both allow the provider access and the schedule of services.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery; however, no more than 10% of the available service hours may be conducted via telehealth

and only the activities as listed above may be done through telehealth. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Only planning activities related to community engagement may be performed through telehealth in this service. Any actual community engagement must be performed in person in the community and not within the individual's residence or a licensed residential or day setting. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is an hour. Community Engagement, alone or in combination with Group Day, Community Coaching, Workplace Assistance, and/or Supported Employment services are limited to no more than 66 hours per week.

These services cannot take place in a licensed residential setting or in the individual's residence other than identified and agreed upon supports using telehealth as documented in the Plan for Supports. The service may not occur in "centers" except for the purpose of exploring community-based interests and activities and gathering general information. These activities may not exceed the allotted 10% of the planned and delivered hours in a month.

When both the individual and the Community Engagement provider (as agreed upon by all parties) are utilizing telehealth platforms, the utilization of telehealth shall not exceed 15% of the authorized and billed hours per month.

These services are provided at a ratio of no more than 3 individuals supported by 1 staff person.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Engagement provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Engagement

Provider Category:

Agency

Provider Type:

Community Engagement provider

Provider Qualifications

License *(specify):*

Community Engagement service providers must be licensed by DBHDS as a provider of non-center based day support services.

Certificate *(specify):*

Other Standard *(specify):*

Community Engagement services providers must have a signed Provider Participation agreement with DMAS in order to provide these services.The provider designated in the Participation Agreement must directly provide the services and bill DMAS for reimbursement. Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

Providers must also assure that persons providing these services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing Community Living Waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers meet DBHDS licensing standards.

DBHDS Office of Licensing staff conduct unannounced and announced onsite and desk reviews of DBHDS licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Guide

HCBS Taxonomy:

Category 1: 13 Participant Training

Sub-Category 1: 13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Community Guide Services include direct assistance to promote individuals' self-determination through brokering very specific community resources that lead to connection to and independent participation in integrated, independent housing or community activities so as to avoid isolation. This means that Community Guides investigate and coordinate as necessary the available, naturally occurring community resources to enable the individual to participate in those resources of interest to him/her. Community Guides provide information and directed assistance that helps the individual in developing supportive community relationships and exploring specific community resources that promote implementation of the person-centered plan. This service involves face to face contact with the individual to determine the individual's specific interests, which may lead to typical community activities or settings in which the individual will engage or reside. In addition to primarily engaging face to face with the individual to identify and explore community resources, there is a component of supporting the individual that may occur without him/her present. Community Guide services involve helping the individual identify the type of community options which maximize the individual's opportunities for meaningful engagement and growth in independence. The Community Guide will provide the in-depth individualized assistance needed to connect with community activities and foster engagement distinct from the generic activities provided through routine case management. This service is designed to be short-term and periodic in nature.

This service may be provided by persons with one of two foci:
I. General community guide:

This involves utilizing existing assessment information regarding the individual's general interests in order to determine specific activities and venues that are available in his community to which he desires to be connected (e.g., clubs, special interest groups, physical activities/sports teams, etc.) in order to promote his inclusion and independent participation in the life of his community. The desired result is an increase in daily or weekly natural supports, as opposed to increasing hours of paid supports.

Allowable Activities:
1. Utilize assessment and other information provided by the case manager in tandem with an in depth discussion with the individual regarding his interests in order to develop a Plan for Supports which contains a step by step strategy for the individual and his family/friends, as appropriate, to carry out in order to reduce barriers and challenges to accessing community resources/activities to support his interests. The plan for supports should identify targeted actions that will promote community integration and independent or naturally supported involvement;
2. Assist the individual in connecting to the identified, non-Medicaid funded community resources by researching and contacting the parties responsible for the identified integrated activities, supports, services, and/or resources delineated in the individual's plan for supports;
3. Provide advocacy and informal counseling that helps guide the individual in problem solving and decision making that enhances the individual's ability to interact and contribute in the local community;
4. Guide the individual and/or demonstrate on site the means of accessing the identified integrated community activities, supports, services, and/or resources;
5. Ensure the individual's active and appropriate utilization of the activities, supports, services and/or resources to which the Community Guide assisted in connecting.

II. Community housing guide:
This involves supporting an individual's move to independent housing by helping with transition and tenancy sustaining

activities. The community housing guide will work in collaboration with the case manager, regional housing specialist, and others to enable the individual achieve and sustain integrated, independent living.

Allowable Activities:
1. Conduct a tenant screening that identifies the individual's preferences and barriers related to successful tenancy;
2. Develop a plan with outcomes and support activities that the community guide will provide to identify and secure safe, affordable housing and assist the individual in the community as he or she implements the plan and work with the case manager to propose recommendations as to waiver support services and activities needed in the Individual Service Plan;
3. Assist with the housing search and application process;
4. Help identify resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
5. Assist in arranging for and supporting the details of the move;
6. Provide education and training on the role, rights and responsibilities of the tenant and landlord during the transition from home or congregate setting;
7. Provide training in being a good tenant and lease compliance; support with activities related to household management as part of the transitional support activities
8. Assist in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action during the period of time that community guide services are authorized; and
9. Assist with the housing recertification process, if or when requested by the case manager or the individual's support team.

All activities may be conducted in either a face-to-face or HIPAA-compliant telehealth method of delivery. Since the COVID-19 pandemic, higher rates of use of telehealth have become standard across many elements of the healthcare and behavioral health practices. The addition of telehealth options to some Virginia Waiver services is not intended to supplant community integration, but rather to complement it. The ability for individuals to connect with providers via HIPAA compliant remote platforms offers the opportunity to prepare and/or plan for community integration opportunities in secure and lower stress environments. The services that serve a community integration purpose are not eligible for 100% telehealth delivery.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Any actual community engagement must be performed in person in the community. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Guide is expected to be a short, periodically intermittent, intense service associated with a specific outcome. An individual may receive one or more of the two types of Community Guide services in an ISP year. Each type of Community Guide service may be authorized for up to 6 consecutive months, and the cumulative total across both may be no more than 120 hours in a plan year.

Community Guide activities conducted not in the presence of the individual, such as researching and contacting potential sites, supports, services and resources, shall not comprise more than twenty-five percent of authorized plan for support hours.

At least fifty percent of the authorized and delivered activities for this service must be conducted through an in-person method of delivery.

The Community Guide will not supplant, replace, or duplicate activities that are required to be provided by the case manager. Prior to accessing funding for this waiver service, all other available and appropriate funding sources, including those offered by Virginia Medicaid State Plan, Division of Rehabilitative Services, and State Department of Education, must be explored and exhausted.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Guide

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Guide

Provider Category:
Individual

Provider Type:
Community Guide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. General Community Guide services may be provided by persons who have successfully completed and received a certificate of completion for both The Learning Community's
• Person-Centered Thinking training and
• Community Connections training.

2. The Community Housing Guide services may be provided by persons who have successfully completed:
• Person-Centered Thinking training
AND
• DBHDS Independent Housing Curriculum Modules 1-3

Providers must have a signed provider participation agreement with DMAS in order to provide Community Guide services. Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

The provider designated in the Participation Agreement must directly provide the services and bill DMAS for reimbursement.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS Provider Enrollment verifies prior to enrollment that Community Guides meet all initial requirements.

DMAS Quality Management Review (QMR) staff verifies that Community Guides have received the required training and continue to comply with service requirements.

Frequency of Verification:

DMAS Provider Enrollment verifies provider participation requirements triennially.

DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community-Based Crisis Supports

HCBS Taxonomy:

Category	Sub-Category
Category 1: 10 Other Mental Health and Behavioral Services	**Sub-Category 1:** 10010 mental health assessment
Category 2: 10 Other Mental Health and Behavioral Services	**Sub-Category 2:** 10030 crisis intervention
Category 3: 10 Other Mental Health and Behavioral Services	**Sub-Category 3:** 10040 behavior support
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community-based crisis supports provides services to individuals experiencing crisis events which put them at risk for homelessness, incarceration, hospitalization, and/or danger to self or others. Community-based crisis supports are ongoing supports to individuals who may have a history of multiple psychiatric hospitalizations; frequent medication changes; enhanced staffing required due to mental health or behavioral concerns; and/or frequent setting changes. Supports are provided in the individual's home and community setting. Crisis staff work directly with and assist the individual and their

current support provider or family. Techniques and strategies are provided via coaching, teaching, modeling, role-playing, problem solving, or direct assistance. These services provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement.

In order to receive community-based crisis supports, the individual shall:
a. Have a history of at least one of the following:
(i). Previous psychiatric hospitalization(s);
(ii). Previous incarceration;
(iii). Lost previous residential/day placements; or
(iv). Behaviors that have significantly jeopardized placement; and

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

The allowable activities include but are not limited to:
1. Psychiatric, neuropsychiatry, and psychological assessment, and other assessments and stabilization techniques;

2. Medication management and monitoring;

3. Behavior assessment and positive behavior support;

4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;

5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community;

6. Assisting with skill building as related to the behavior creating the crisis in areas such as self-care/ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, and medication compliance.

7. Supervision to ensure the individual's safety and the safety of others in the environment.

Community -based crisis supports is only provided to individuals age 21 and over. All medically necessary community-based crisis supports for children under age 21 are covered in the state plan pursuant to the EPSDT benefit."

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provision limited to six months per year to be authorized in 30 day increments. Requests for this service in excess of the annual limit will be considered if justification of individual need is provided.

In accordance with the CMS Informational Bulletin issued on July 7, 2014, community-based crisis supports for individuals under age 21 shall be accessed through the state plan pursuant to ESPDT. community-based crisis supports through this waiver shall not be available to individuals under age 21.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Crisis Supports Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community-Based Crisis Supports

Provider Category:

Agency

Provider Type:

Community-Based Crisis Supports Provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must have a signed provider participation agreement with DMAS in order to provide Community-based crisis supports. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The QDDP providing community-based crisis supports must have:
1. At least one year of documented experience working directly with individuals who have developmental disabilities,
2. A bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; or a bachelor's degree in another field in addition to an advanced degree in a human services field; and
3. The required Virginia or national license, registration, or certification, as is applicable, in accordance with his or her profession.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of community-based crisis services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

DBHDS Office of Licensing staff conducts unannounced and announced onsite and desk reviews of DBHDS licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews or desk audits of the records at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Companion services provide nonmedical care, socialization, or support to individuals. This service is provided in an individual's home or at various locations in the community.

The allowable activities include:
1. Assistance or support with tasks such as meal preparation, laundry, and shopping;
2. Assistance with light housekeeping tasks;
3. Assistance with self-administration of medication;
4. Assistance or support with community access and recreational activities; and
5. Support to assure the safety of the individual.

Individuals are afforded the opportunity to act as the employer in the consumer-direction of companion services. This involves hiring, training, supervision, and termination of companions. Individuals choosing to receive services through the consumer-directed model may do so by choosing a services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) to provide the training and guidance needed to be an employer. If the individual is unable to independently manage his/her own consumer-directed services, an adult family member/caregiver or other chosen person must serve as the employer of record (EOR) on behalf of the individual.

Unlike personal assistance and residential support, companion services do not permit routine support with activities of daily living (such as toileting, bathing, dressing, grooming). The allowable activities center on instrumental activities of daily living (meal prep, shopping, community integration, etc.).

Companion services are provided in a one-to-one fashion and are thus occasionally coupled with residential support if an individual has a desire to pursue community interests distinct from roommates and does not have the need for support with ADLs during the time of companion services provision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individual must be 18 years of age or older to receive this service.

Service delivery may not exceed 8 hours per day.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer-Directed Companion
Agency	Companion Services Provider (Agency-Directed)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Individual

Provider Type:

Consumer-Directed Companion

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Companions do not need to be enrolled with DMAS (i.e., have a participation agreement) to provide consumer-directed companion services.

Companion qualifications include the following requirements. The companion must:

a. Be 18 years of age or older and possess a valid Social Security number that has been issued by the Social Security Administration to the person who is to function as the assistant;
b. Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;
c. Have the required skills and physical abilities to perform the services as specified in the individual's Plan for Supports;
d. Be willing to attend training at the individual's and the family/caregiver's, and EOR's, as appropriate, request;
e. Understand and agree to comply with the DMAS requirements; and
f. Receive a tuberculosis screening according to VDH guidelines.

The CD companion must submit to a criminal history record checks for barrier crimes, as defined in 12VAC30-120-1000, within 30 days from the date of employment. The companion will not be compensated for services provided to the

individual subsequent to the receipt of a records check verifying that the companion has been convicted of crimes according to the requirements of the Code of Virginia, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual/employer of record is responsible for the verification of
- the employee's skill set,
- the employee's willingness to attend training upon request,
- possession of basic math, reading & writing skills,
- compliance with Waiver requirements, and
- receipt of verification of an annual TB screening according to VDH guidelines.

The Fiscal Management Services (FMS) is responsible for verifying that
- the employee meets the minimum age requirement,
- the employee possesses a valid SSN,
- the criminal records check is completed.

Frequency of Verification:

Initially upon hire.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

Companion Services Provider (Agency-Directed)

Provider Qualifications

License *(specify):*

The following types of providers can deliver companion services:

1. Providers licensed by DBHDS as a provider of group home residential services, supportive in-home residential services, non-center based day support, or respite services; or

2. Personal care agencies licensed by the Virginia Department of Health or that have accreditation from any organization recognized by the CMS for the purposes of Medicare certification.

Certificate *(specify):*

Other Standard *(specify):*

Companion providers must have a signed Provider Participation agreement with DMAS in order to provide Companion services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers of companion services must employ individuals who meet the following requirements:

1. Are 18 years of age or older and possess a valid Social Security Number;

2. Are able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;

5. Have the required skills to perform services as specified in the individuals service plan with minimal supervision;

6. Are capable of following a service plan with minimal supervision;

7. Submit to criminal history record check within 30 days from the date of employment. The companion will not be compensated for services provided to the individual subsequent to the receipt of a records check verifying that the companion has been convicted of crimes according to the requirements of the Code of Virginia, as applicable;

8. Receive an annual tuberculosis (TB) screening according to VDH guidelines; and

9. Are capable of aiding the individual in the instrumental activities of daily living.

Companions must be employees of providers that contract with DMAS to provide companion services. Providers are required to have a companion supervisor to monitor companion services. The supervisor must have a bachelor's degree in the human services field and at least one year of experience working in the DD field, or be an RN or LPN with at least one year of experience working in the DD field. A RN must have a current license or certification to practice nursing in the Commonwealth within his or her profession.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that DBHDS-licensed providers of Companion services meet DBHDS licensing standards.

VDH verifies that VDH licensed providers meet VDH licensing standards.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced onsite reviews of DBHDS-licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of companion services providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10010 mental health assessment

Category 2:	Sub-Category 2:

10 Other Mental Health and Behavioral Services

10030 crisis intervention

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Crisis Support services provide intensive supports by appropriately trained staff in the area of crisis prevention, crisis intervention, and crisis stabilization to an individual who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize their current community living situation. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period. This service may be provided in all community settings including licensed and unlicensed homes, programs, etc. All providers are required to train staff on individual rights and to ensure rights are safeguarded.

a. Crisis Prevention - Crisis prevention services provide ongoing assessment of an individual's medical, cognitive, and behavioral status as well as predictors of self injurious, disruptive, or destructive behaviors, with the initiation of positive behavior supports to prevent occurrence of crisis situations. Crisis prevention also encompasses providing support to the family and the individual through facilitating team meetings, revising the behavior plan, etc. as they implement changes to the plan for support and address any residual concerns from the crisis situation. Staff will arrange to train and mentor staff or family members who will support the individual long term once the crisis has stabilized in order to minimize or prevent recurrence of the crisis. Crisis support staff will deliver such support in a way that maintains the individual's typical routine to the maximum extent possible.

b. Crisis Intervention - Crisis intervention services are used in the midst of the crisis to prevent the further escalation of the situation and to maintain the immediate personal safety of those involved. Crisis Intervention is a relatively short term service that provides a highly structured intervention that may include temporary changes to the person's residence, removal of certain items from the setting, changes to the person's daily routine, and emergency referrals to other care providers. Those providing crisis intervention services must also be well-versed and fluent in verbal de-escalation techniques, including active listening, reflective listening, validation, and suggestions for immediate changes to the situation.

c. Crisis Stabilization - Crisis stabilization services begin once the acuity of the situation has resolved and there is no longer an immediate threat to the health and safety of those involved. Crisis stabilization services are geared toward gaining a full understanding of all of the factors that precipitated the crisis and may have maintained it until trained staff from outside the immediate situation arrived. Crisis stabilization plans are developed by staff trained in basic behavioral treatment and crisis management. These plans may include modifications to the environment, interventions to enhance communication skills, or changes to the individual's daily routine or structure. Staff developing these plans must be able to train support staff, family, and other significant persons in the individual's life.

Crisis support services is only provided to individuals age 21 and over. All medically necessary crisis support services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit."

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provision is subject to the following limits:
60 days per individual service plan year of crisis prevention
90 days per individual service plan year of crisis intervention (authorized in 15 day increments)
60 days per individual service plan year of crisis stabilization (authorized in 15 day increments)
The service unit is hourly. Billing may occur up to 24 per day if necessary.

In accordance with the CMS Informational Bulletin issued on July 7, 2014, crisis support services for individuals under age 21 shall be accessed through the state plan pursuant to ESPDT. Crisis support services through this waiver shall not be available to individuals under age 21.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Crisis Support Services provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Support Services

Provider Category:

Agency

Provider Type:

Crisis Support Services provider

Provider Qualifications

License *(specify):*

A crisis support services provider must be licensed by DBHDS as a provider of residential crisis stabilization services or nonresidential crisis stabilization services.

In addition to meeting the above licensing requirements, the clinical services provider must employ or utilize qualified developmental disability professionals (QDDPs), licensed mental health professionals, or other personnel competent to provide clinical or behavioral interventions. These might include crisis counseling, behavioral consultation, or related activities to individuals with DD who are experiencing serious psychiatric or behavioral problems. The face-to-face assessment or reassessment required to initiate or continue this service must be conducted by a QDDP.

The QDDP providing crisis stabilization clinical/behavioral intervention services must have:

1. At least one year of documented experience working directly with individuals who have developmental disabilities;

2. At least a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and

3. The required Virginia or national license, registration, or certification, as is applicable, in accordance with his or her profession.

Virginia attests that no duplication of crisis stabilization in the waiver and EPSDT services will be permitted and will ensure that each child has access to all services to which he/she is entitled through EPSDT.

Certificate *(specify):*

Other Standard *(specify):*

Crisis support services providers must have a signed provider participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

All providers are required to train staff on individual rights and to ensure rights are safeguarded.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of crisis support services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff are QDDPs.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced onsite reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Electronic Home-Based Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This includes purchases of electronic devices, software, services, and supplies not otherwise provided through this waiver or through the State Plan, that would allow individuals to access technology that can be used in the individual's residence to support greater independence and self-determination. Portable handheld devices that may be used by the individual at home or in the community may also be covered.

The service will support the assessment for determining appropriate equipment/devices, acquisition, training in the use of

these goods and services, ongoing maintenance and monitoring services to address an identified need in the individual's person-centered service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements: the item or service will decrease the need for other Medicaid services (e.g., reliance on staff supports); AND/OR promote inclusion in the community; AND/OR increase the individual's safety in the home environment.
These electronic goods and services are purchased for the individual. Examples are electronic devices that verbally prompt the individual to turn off the stove or lock the front door and sensors that provide a family member or provider with information about the individual's movements around his/her living area. This service includes ongoing electronic monitoring, which is the provision of oversight and monitoring within the home of the adult individual (18 years and older) through off-site monitoring which includes live video feed; live audio feed; motion sensing system; radio frequency identification (RFID); web-based monitoring system; or other devices approved by DBHDS/DMAS. The system shall include devices to engage in live, two-way communication with the individual being monitored. Also included is the provision of stand-by intervention staff prepared for prompt engagement with the individual and/or immediate deployment to the residential setting in critical situations.

In situations in which EHBS will include live video and/or audio feed, the individual, legal guardian, authorized representative will be required to sign a consent form which acknowledges their agreement to some degree of compromise to the individual's privacy in exchange.

Remote monitoring may be on-site or on-call depending on the type of service/device. If the EHBS is a remote monitoring system which either "checks on" the individual or through which the individual can "check in," the monitors would be off-site but have the necessary emergency contact information for nearby helpers (case manager, family members, provider staff, as appropriate) in order to mobilize local help. EHBS may also be something that alerts the individual directly that his door is unlocked, faucet or stove is on for an extended period of time, etc. Other types of EHBS may be a portable device that "talks" the person through steps of a task (cooking, washing clothes, etc.), which may be followed up by family or staff later.

Enabling individuals to live in their own apartments/homes in the community without the presence of 24/7 staff is considered to be more integrated than living in a group home (where EHBS is not permitted) or other "congregate" style setting. EHBS lends an additional layer of safety to individuals to support their living in such integrated settings, particularly when staff are not present.

The service does not permit video monitoring devices in the individual's bedroom or bathroom. The individual may disable any monitoring device in their private residence whenever he sees fit. If other individuals reside in the same home, documentation is required and agreements/waivers may obtained if the situation warrants them.

As with any other approved waiver service, EHBS support needs must be addressed in the person centered ISP. Signatures are required by the individual and/or his substitute decision make on the PC ISP and relevant provider plans for supports (including EHBS).

EHBS requires the completion of a professional assessment prior to authorization. The assessment identifies the individual's needs and how EHBS will successfully address them. This assessment is submitted with the authorization request along with supporting documentation from the selected provider of service.

The EHBS provider is responsible for installation and maintenance of any necessary equipment/technology. This includes explanations and planning should a technology failure occur.

Video monitoring devices are not permitted in the individual's bedroom or bathroom. A video monitoring device is only permitted in the "common rooms" of the home. Other technology or equipment monitoring devices (such as a stove monitor or water flow monitor) would be installed as needed/assessed. These devices do not violate or interfere with the individual's right to privacy. The needs are addressed in the required assessment.

The individual and/or substitute decision maker have final authority/control over the EHBS technology. The monitoring devices may be turned off whenever needed or wanted. The case manager and provider have the responsibility of ensuring the individual is aware of his rights and it is documented in the PC ISP and provider plan for supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A preliminary needs assessment will be conducted by a independent professional consultant to help determine the best type and use of technology and the overall cost effectiveness of various options.

The maximum Medicaid-funded expenditure for assistive technology and Electronic Home-Based Services is $10,000 per service plan year. An individual, based on their needs, may allocate a portion or all of the service plan year cap towards one or a combination of the two services.

This service will not be available to individuals receiving residential supports that are reimbursed on a daily basis (e.g., group home, sponsored or supported living residential services).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Electronic Home-Based Supports Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Electronic Home-Based Services

Provider Category:

Agency

Provider Type:

Electronic Home-Based Supports Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

EHBS providers must have a signed provider participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The independent professional consultant conducting the preliminary assessment may be an occupational therapist, Board Certified Behavior Analyst, or other similarly credentialed specialist who is licensed or certified by the Commonwealth of Virginia and specializes in assistive technologies, mobile technologies and smart home accommodations for people with developmental disabilities or other similarly credentialed specialist

An EHBS provider shall be one of the following:

(i) an enrolled personal care agency;
(ii) an enrolled durable medical equipment provider;

(iii) a CSB
(iv) a Center for Independent Living
(v) a licensed home health provider;
(vi) an EHBS manufacturer that has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring services; or
(vii) a PERS manufacturer that has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring services.

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

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

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

An EHBS provider shall install, test, and demonstrate to the individual and family/caregiver, as appropriate, the unit or device before submitting his claim for services to DMAS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Virginia Department of Medical Assistance Services

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews or desk audits of the records at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment and community transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

This service is offered in order to enable individuals to gain access to an individual's place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available. The goal of this service is to promote the individual's independence and participation in the life of his community. Use of this service must be related to the individual's desired outcomes as stated in the ISP. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them.

The service may include transportation in a private vehicle by a person such as a co-worker or other community member or the purchase of tickets for public transportation such as bus or subway. In either case, an administering agency will coordinate and bill DMAS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service shall not be authorized or reimbursed for individuals who can access transportation through the State Plan or other waiver services which include a transportation component. The individual or legal guardian must verify that he does not have sufficient personal financial resources (e.g., through wages) to cover the cost of the transportation himself. Private transportation is reimbursed according to a "trip" and the number of individuals being transported to the location (maximum of three). There are three trip rates depending on the distance traveled:

1. Under 10 miles
2. Between 10 - 20 miles
3. Over 20 miles

The purchase of tickets for public transportation and dissemination to the individual is coordinated by the administering agency.

A provider delivering another waiver service to an individual may not utilize staff to provide Employment and Community Transportation and may only bill for this service if the transportation would not be a normally required element of service provision.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Employment and Community transportation provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment and community transportation

Provider Category:

Individual

Provider Type:

Employment and Community transportation provider

Provider Qualifications

License *(specify):*

The service will be offered through an administering agency that possesses any DBHDS license to provide services to individuals with developmental disabilities, a Center for Independent Living or an Employment Service Organizations. Administering agencies shall be enrolled with DMAS (i.e., has a participation agreement) to provide these services.

Certificate *(specify):*

Other Standard *(specify):*

In the case of private transportation, the administering agency will be responsible for screening community persons to drive the individual to the designated location(s) according to the ISP.
The private driver must:
1. Be 18 years of age or older;
2. Possess a valid driver's license;
3. Possess and maintain at a minimum (1) proof of general liability insurance coverage in compliance with federal and/or state statutory requirements and (2) a satisfactory driving record defined as no reckless driving charges within the past 24 months. The insurance should insure the insured or the passengers:
a. Against loss from any liability imposed by law for damages;
b. Against damages for care and loss of services, because of bodily injury to or death of any person;
c. Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth, any other state in the United States, or Canada;
d. Subject to a limit of exclusive of interest and costs, with respect to each motor vehicle of $25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of $50,000 because of bodily injury to or death of two or more persons in any one accident; and
e. Subject to a limit of $20,000 because of injury to or destruction of property of others in any one accident.

Verification of Provider Qualifications

Entity Responsible for Verification:

The administrative entity is responsible for the verification of the private driver's:
1. possession of a current, valid driver's license and no reckless driving charges within the past 24 months,
2. possession of car insurance,
3. ensuring that the driver meets the minimum age requirement of age 18,
4. completion of an attestation signed by the private driver, the individual, and the individual's guardian or authorized representative, as appropriate, that the driver has disclosed any relevant felonies and if listed on any registry. The administering agency will ensure that the driver is not listed on the Virginia Sex Offender Registry.

Frequency of Verification:

Initially and annually the administering provider will verify and document that each private driver possesses a current, valid driver's license and car insurance.
DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental modifications are physical adaptations to the individual's primary home or primary vehicle that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence. 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.

Allowable activities include:

1. Physical adaptations to a house or place of residence necessary to ensure an individual's health, welfare and safety (e.g., installation of specialized electric and plumbing systems to accommodate medical equipment and supplies);

2. Physical adaptations to a house or place of residence which enable an individual to live in a noninstitutional setting and to function with greater independence that do not increase the square footage of the house or place of residence (e.g., installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities);and

3. Modifications to the primary vehicle being used by the individual.

Exclusions to this service are those modifications, adaptations or improvements to the home which are of general utility and are not intended to provide a direct medical or remedial benefit to the individual (i.e., carpeting, roof repair, central air conditioning.) Further, environmental modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded are modifications that are reasonable accommodation requirements of the American's with Disabilities Act, Virginians with Disabilities Act, and the Rehabilitation Act. Modifications, adaptations or improvements, which add to the total square footage of the home, are not allowable expenditures except when necessary to complete an adaptation, as determined through preauthorization. All modifications must meet current building code.

The case manager submits service plan information to the operating agency, DBHDS for service authorization. DBHDS employs Qualified Developmental Disability Professionals (QDDPs) to complete the approval/service authorization process.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum Medicaid-funded expenditure for environmental modifications is $5,000 per year.

EM shall be available to individuals enrolled in the waiver who are receiving at least one other waiver service.

Environmental modifications shall be provided in the least expensive manner possible that will accomplish the modification required by the individual. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program.

Environmental modifications are not allowed to be reimbursed for the work site, community activity setting or day program (which exceed reasonable accommodation requirements of the employer under the Americans with Disabilities Act).

The services under the Community Living Waiver, VA.0372.R04.00, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Modifications Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Environmental Modifications Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Environmental modifications shall be provided in accordance with all applicable federal, state, or local building codes and laws by CSB contractors or DMAS-enrolled providers.

Providers must have a signed provider participation agreement with DMAS in order to provide environmental modification services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Providers may also go through the CSB's Organized Healthcare Delivery Systems (OHCDS) as a provider.

The contractor must:

1. Comply with all applicable state and local building codes, with accommodations to meet the individuals needs (code variations permitted in individuals residences, excluding group homes);

2. If used previously, have satisfactorily completed previous environmental modifications; and

3. Be available for any service or repair of the environmental modifications.

One modification may require the collaboration of up to three different providers:

1. A rehabilitation engineer or certified rehabilitation specialist (CRS) may be used in cases where structural modifications of the primary residence are requested to evaluate the individual's needs and subsequently act as project manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the rehabilitation engineer may actually design and personally complete the modification. A physical therapist or occupational therapist, available through the State Plan for Medical Assistance or waiver therapeutic consultation, may also be utilized to evaluate the needs for environmental modifications, when appropriate;

2. A building contractor may design and complete the structural modification; and

3. A vendor who supplies the necessary materials may be separately reimbursed, or supplies may be included in the bill of the building contractor or rehabilitation engineer.

A rehabilitation engineer/CRS may be required if (for example):

The environmental modification involves combinations of systems which are not designed to go together.

The structural modification requires a project manager to assure that the design and functionality meet ADA accessibility guidelines.

Where structural modifications of the primary residence are requested to ensure the residence is structurally sound for the modifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of environmental modifications providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Group Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Group Supported Employment is defined as continuous support provided by staff in a naturally occurring place of employment to groups of two to eight individuals with disabilities and involves interactions with the public and coworkers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community.

Group Supported Employment must be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace.

These supports enable an individual to obtain and maintain a job in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Group supported employment settings shall comply with the HCBS settings requirements per 42 CFR 441.301.

The allowable activities are:

1. Vocational/job-related discovery or assessment;

2. Person-centered employment planning which results in employment related outcomes;

3. Negotiation with prospective employers;

4. On-the-job training in work skills required to perform the job;

5. Ongoing evaluation, supervision, and monitoring of the individual's performance on the job but which do not include supervisory activities rendered as a normal part of the business setting;

6. Ongoing support services necessary to assure job retention;

7. Supports to ensure the individual's health and safety;

8. Development of work-related skills essential to obtaining and retaining employment, such as the effective use of community resources and break/lunch areas and transportation systems; and

9. Staff coverage for transportation between the individual's place of residence and the workplace when other forms of transportation are unavailable or inaccessible (i.e., time spent transporting).

The following identified activities may be performed in either a face-to-face or via a HIPAA-compliant telehealth platform where the ISP clearly identifies the elements to be delivered via telehealth:
1. Elements of job-related discovery;
2. Employment planning;
3. Individualized job development;
4. Employment negotiation;
5. Job training;
6. Job retention; and
7. Development of work-related skills.

Personal care activities are not typically provided, but may be included. The individual's assessment and individual support plan must clearly reflect the individual's need for employment-related skill building.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery; however, no more than 10% of the available service hours may be conducted via telehealth and only the activities as listed above may be done through telehealth. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is an hour. Supported employment services, alone or in combination with Community Engagement, Community Coaching, Workplace Assistance, and/or Group Day services are limited to no more than 66 hours per week.

Providers for persons eligible for or receiving supported employment services funded under § 110 of the Rehabilitation Act of 1973 (through DARS) or §§ 602(16)(17) of the Individuals with Disabilities Education Act (IDEA) (through special education services) cannot receive payment for this service through Community Living waiver services. The case manager must assure that supported employment services are not available through these sources and document the finding in the individual's case management record. When services are provided through these sources, the individual support plan will not include them as a requested waiver service.

When both the individual and the Supported Employment provider (as agreed upon by all parties) are utilizing telehealth platforms, the utilization of telehealth shall not exceed 10% of the authorized and billed units per month.

FFP is not available for any activities with incentive payments, subsidies, or unrelated vocational training expenses.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group Supported Employment provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Group Supported Employment

Provider Category:

Agency

Provider Type:

Group Supported Employment provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers shall be DARS-contracted providers of supported employment services.

Supported employment providers must have a signed provider participation agreement with DMAS in order to provide supported employment services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Verification of Provider Qualifications

Entity Responsible for Verification:

DARS verifies that these providers meet criteria to be providers through a DARS-recognized accreditation body.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of supported employment providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

In-home Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

In-Home Support services are residential services that take place in the individual's home, family home, or community settings and typically supplement the primary care provided by the individual, family or other unpaid caregiver. In-Home Support services are designed to ensure the health, safety and welfare of the individual. These services shall consist of skill-building, routine supports, general supports, and safety supports, 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.

Payment is not to be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Each individual and family/caregiver, 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. Utilization of telehealth is not considered an appropriate backup plan for purposes of the hands-on components of this service.

Since the COVID-19 pandemic, higher rates of use of telehealth have become standard across many elements of the healthcare and behavioral health practices. The addition of telehealth options to some Virginia Waiver services is not intended to supplant community integration, but rather to complement it. The ability for individuals to connect with providers via HIPAA compliant remote platforms offers the opportunity to prepare and/or plan for community integration opportunities in secure and lower stress environments. The services that serve a community integration purpose are not eligible for 100% telehealth delivery.

The allowable activities are:

1) Skill-building related to personal care activities (toileting, bathing, and grooming; dressing; eating; mobility; communication; household chores; food preparation; money management; shopping, etc.);

2) Skill-building related to the use of community resources (transportation, shopping, dining at restaurants, participating in social and recreational activities, etc.);

3) Supporting the individual in developing the ability to replace challenging behavior with positive, accepted behavior for home and community environments, for example (not all inclusive):

- Developing a circle of friends;

- Handling social encounters with others; or

- Redirecting challenging behavior.

4) Monitoring health and physical conditions and providing supports with medication or other medical needs;

5) Providing supports with personal care, ADLs, and use of community resources, for example (not all-inclusive):

- Completing personal care or mealtime tasks when physically unable to do so; or

- Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the individual's health and welfare.

6) Supporting with transportation to and from community resources; and

7) Providing safety supports to ensure the individual's health and safety.

In-home Support services include the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

Allowable activities may be conducted in either a face-to-face or HIPAA-compliant telehealth method of delivery; however, activities with a hands-on component cannot be performed via telehealth.

There is, however, a small cohort of individuals (particularly individuals being discharged from the Training Center who are extremely medically fragile and/or behaviorally challenged), for whom customized rates will be necessary.

INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:
These extremely medically fragile and/or behaviorally challenged individuals are those whose support needs place them in levels six or seven but who have a higher level of need than will be accommodated by the tier four rates, as well as any individual for whom it is determined that the only other resource is to be served out of state, in a state operated mental health or DD facility, or in a more restrictive environment. They are identified as those who require greater support in order to find in-state providers willing to serve them. These individuals' needs outweigh the resources provided within the current waiver rate structure. Their needs may warrant:

- Increased staffing ratios, and/or
- Higher credentialed staff, and/or
- Increased programmatic oversight.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports. This level of staff intervention allows for appropriate supervision both in the home, as well as in the community to prevent and/or reduce social isolation. Shared staffing ratios in these more unique cases (as typically occur in group homes and day services) often do not provide adequate oversight as staff is required to work directly with such individuals to prevent, mitigate, or respond immediately to behavioral incidents, while another staff protects others in the area to ensure all individuals in the setting are safe. In addition, the supervision and oversight required by more experienced/highly trained direct support staff requires clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.

Medically, an individual may require 1:1 or 2:1 staff support when he has a health history or recent health complication that puts him at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during meal time due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that he may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff are provided during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as total personal care and the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports

outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery; however, any tasks that have a hands-on or community integration component are required to be performed in-person and cannot be done via telehealth. Any individual who uses telehealth for this service shall have his/her privacy respected while skill building of ADLs is being performed. The provider will take all necessary precautions to ensure the privacy and dignity of the individual are protected when supporting the individual in the development of personal care skills. In any instance where personal care skills are being provided via telehealth, it should be noted clearly in the service plan and communicated to the person and/or his/her substitute decision maker that they understand what is involved in telehealth delivery. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. Any allowable activities that involve a community integration aspect are required to be done in person. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is an hour.

In-home support services are typically not provided 24 hours per day, but may be when appropriately justified.

Utilization of telehealth platforms shall not exceed 20% of authorized and delivered services, except for circumstances listed below.

Individuals who are receiving this service under a Customized Rate, may, due to extraordinary behavioral needs or medical needs as listed under Service Definition, be found ineligible from receiving identified activities via a telehealth platform due to their direct, frequent, and intensive 1:1 or 2:1 staffing needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	In-home Supports provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In-home Support Services

Provider Category:

Agency

Provider Type:

In-home Supports provider

Provider Qualifications

License *(specify):*

An agency licensed by DBHDS as a provider of supportive in-home residential services.

Certificate *(specify):*

Other Standard *(specify):*

In-home Supports providers must have a signed provider participation agreement with DMAS in order to provide residential services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

Providers must also assure that persons providing In-home Supports have received training in the characteristics of IDD and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of In-home Supports meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced onsite reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Mentor Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Peer Mentor Supports provide information, resources, guidance, and support from an experienced, trained peer mentor to an individual who is a waiver recipient. This service is delivered to waiver recipients by other individuals with developmental disabilities who are or have been service recipients, have shared experiences with the individual, and provide support and guidance to him/her. The service is designed to foster connections and relationships which build individual resilience. Peer Mentor Supports encourage individuals with developmental disabilities to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with waiver participants so that the waiver participant is better able to advocate for and make a plan to achieve integrated opportunities and experiences in living, working, socializing, and staying healthy and safe in his/her own life, as well as to overcome personal barriers which are inhibiting him/her from being more independent. Peer mentoring is intended to assist with empowering the individual receiving the service. This service is delivered based on the support needs of the individual as outlined in his/her person-centered plan. This service is designed to be short-term and periodic in nature.

Allowable Activities
1. The administering agency facilitates peer to peer "matches" and follows up to assure the matched relationship meets the individual's expectations;
2. The peer mentor has face to face contact with the individual to discuss his/her specific interests/desired outcomes related to realizing greater independence and the barriers to achieving them;
3. The peer mentor explains community services and programs and suggests strategies to the individual to achieve his/her desired outcomes, particularly related to living more independently, engaging in paid employment and expanding social opportunities in order to reduce the need for supports from family members or paid staff;
4. The peer mentor provides information from his/her experiences to help the individual in problem solving, decision making, developing supportive community relationships and exploring specific community resources that promote increased independence and community integration;
5. The peer mentor assists the individual in developing a personal plan for accessing the identified integrated community activities, supports, services, and/or resources.

All activities may be conducted in either a face-to-face or HIPAA-compliant telehealth method of delivery.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and

to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. The activities allowed to be performed via telehealth are meant to assist the individual in developing a plan and supports so that the individual can achieve greater community engagement and integration. Actual community engagement does not occur within this service; rather, the peer mentor shares his/her experiences as part of a means to enable the individual in interacting with his/her community with a more positive outcome. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Peer Mentor Supports is expected to be a short, periodically intermittent, intense service associated with a specific outcome. Peer Mentor Supports may be authorized for up to 6 consecutive months, and the cumulative total across that timeframe may be no more than 60 hours in a plan year.

The Peer Mentor will not supplant, replace, or duplicate activities that are required to be provided by the case manager. Prior to accessing funding for this waiver service, all other available and appropriate funding sources must be explored and exhausted.

Peer Mentors cannot mentor their own family members.

Peer Mentors must be at least 21 years of age and may provide these supports only to individuals 16 years of age and older.

Allowable activities that can be performed using telehealth can be performed for up to 100% of the service hours.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Peer Mentor Administrating Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Mentor Supports

Provider Category:

Agency

Provider Type:

Peer Mentor Administrating Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Peer Mentor Supports are provided by an individual with a developmental disability who has lived independently in the community for at least one year and is or has been a recipient of services, including but not limited to publicly-funded housing, Medicaid waiver services, work incentives, and supported employment.

The peer mentor must have completed DBHDS's DD Peer Mentor training curriculum and passed the accompanying test. The curriculum focuses on mentoring skills, effective communication, individuals' rights and responsibilities as citizens, participating in person-centered planning, as well as knowledge of community systems and services that support integrated employment and living in the community.

Individuals who receive supports through DD or other waivers may be peer mentors.

The Peer Mentor Supports administering agency must have a signed provider participation agreement with DMAS. Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS verifies provider agency qualifications initially and subsequently every three years.

Frequency of Verification:

DMAS verifies provider agency qualifications initially and subsequently every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:

Personal Emergency Response System (PERS) is an electronic device and monitoring service that enable certain individuals to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.
PERS is 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.
PERS services may be authorized when there is no one else in the home with the individual who is competent or continuously available to call for help in an emergency.
Medication monitoring units must be physician ordered and are not considered a stand-alone service. Individuals must be receiving PERS services and medication monitoring service simultaneously.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Personal Emergency Response System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

PERS providers must have a signed provider participation agreement with DMAS in order to provide PERS services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.
(i) an enrolled personal care agency; (ii) an enrolled durable medical equipment provider; (iii) a licensed home health provider; (iv) a hospital; or (v) a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring services.
The PERS provider must provide an emergency response center with fully trained operators who are capable of receiving signals for help from an individual's PERS equipment 24-hours a day, 365, or 366, days per year as appropriate, of determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the PERS service individual needs emergency help.
The PERS provider shall have the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit.
The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line or cellular system and must furnish all supplies necessary to ensure that the PERS system is installed and working properly.
The PERS installation shall include local seize line circuitry, which guarantees that the unit shall have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.
A PERS provider shall install, test, and demonstrate to the individual and family/caregiver, as appropriate, the PERS system before submitting his claim for services to DMAS.
The PERS provider shall have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.
All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard for home health care signaling equipment (in Underwriter's Laboratories Safety Standard 1637, Standard for Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006). The UL listing mark on the equipment shall be accepted as evidence of the equipment's compliance with such standard. The PERS device shall be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the individual enrolled in the waiver or family/caregiver, as appropriate.
The PERS provider shall be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.
DMAS QMR staff review a sample of PERS providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individual and continuous care (in contrast to part-time or intermittent care) for individuals with a serious medical condition and/or complex health care need, certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility or ICF-IID. One-to-one care is provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse.

These services are provided to an individual at their place of residence or other community settings.

The allowable activities include:

1. Monitoring of an individual's medical status;

2. Assistance with Activities of Daily Living (ADLs) in conjunction with medical treatment and care;

3. Administering medications and other medical treatment; or

3. Training, consultation, nurse delegation or oversight of family members, staff, and other persons responsible for carrying out an individual's support plan for the purpose of monitoring the individual's medical status and administering medications and other medically- related procedures consistent with the Nurse Practice Act [18VAC90-20-10 et seq., by statutory authority of Chapter 30 of Title 54.1, Code of Virginia].

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is a quarter hour.

Individuals receiving Skilled Nursing services, beyond nurse delegation responsibility activities, shall not be authorized for Private Duty Nursing services.

In accordance with the CMS Informational Bulletin issued on July 7, 2014, private duty nursing for individuals under age 21 shall be accessed through the state plan pursuant to ESPDT. Private duty nursing through this waiver shall not be available to individuals under age 21.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Duty provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty provider

Provider Qualifications

License *(specify):*

Private duty nursing services may be provided by either

1) a licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN employed by a DMAS-enrolled home health provider, or

2) a licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN who is contracted with or employed by a DBHDS-licensed day support, respite, or residential provider.

The RN or LPN must have a current license issued by the Virginia Board of Nursing or a current multi-state licensure privilege to practice nursing in the Commonwealth as an RN or LPN, as applicable.

Certificate *(specify):*

Other Standard *(specify):*

Private duty nursing providers must have a signed provider participation agreement with DMAS in order to provide private nursing services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers that have a DMAS participation agreement to provide home health services or a DMAS-enrolled Home Care Organization (HCO) may provide private nursing services under that agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Health Professions verifies credentials of registered nurses and licensed practical nurses.

The Virginia Department of Medical Assistance Services verifies provider qualifications.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of private nursing providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Shared Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
07 Rent and Food Expenses for Live-In Caregiver	07010 rent and food expenses for live-in caregiver
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Shared Living is the Medicaid payment for a portion of the total cost of rent, food, and utilities that can be reasonably attributed to a person who has no legal responsibility to support the individual and resides in the same household as the individual. The person delivering shared living services is essentially a "roommate" who does, by definition, live with the individual receiving waiver supports. These expenses may be covered when the roommate provides companionship supports, including fellowship and enhanced feelings of security, and limited ADL or IADL supports that account for no more than 20% of the anticipated companionship time on a weekly basis. The support provided by the roommate will be agreed upon by the individual and the live- in companion/roommate, and individually determined through a person-centered planning process.

Companionship supports may include:

• The provision of fellowship, which means to engage the individual in social, physical or mental activities, such as conversation, games, crafts, accompanying the person on walks, errands, appointments and social and recreational activities.
• Enhanced feelings of security which means to provide necessary social and emotional support to the individual when inside or outside of the residence.

ADL and IADL supports may also be provided, but will account for no more than 20% of the anticipated companionship time, and may include:

• Assistance with Instrumental Activities of Daily Living (IADLs) which are tasks that enable a person to live independently at home, such as meal preparation, light housework, assistance with the physical taking of medications
• Assistance with Activities of Daily Living (ADLS), either with routine prompting and/or intermittently providing direct assistance for ADLS such as dressing, grooming, feeding, bathing, toileting and transferring.

The individual will choose who lives with him/her and together, through a person centered process, determine the companionship supports provided based on preferences and need. The roommate will not have the responsibility for providing habilitative services or medical services. While the roommate may provide a certain percentage of the service delivery time providing assistance with personal care tasks the main objective of this service is to provide general fellowship, as any roommate would do, both in the home and in settings in the community. The shared living roommate is not a paid staff person.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment will not be made directly to the roommate but to a provider agency that will in turn transfer the appropriate amount of funds to the individual. The service is available to adult individuals, aged 18 years of age or older.

The individual must reside in his or her own home or leased residence. Payment will not be made when the individual lives in the roommate's home, in a residence that is owned or leased by the provider agency, or any other residential arrangement where the individual is not directly responsible for the residence.

The roommate must not be the individual's parent, spouse, grandparent, or guardian.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Shared Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Shared Living

Provider Category:

Agency

Provider Type:

Shared Living

Provider Qualifications

License *(specify):*

Any DBHDS licensed provider may be the administrative provider.

Certificate *(specify):*

Other Standard *(specify):*

Administrative Providers must have a signed provider participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement must coordinate the services, which may include roommate matching as needed, background checks, training, periodic onsite monitoring, and disbursing funds to the individual; and bill DMAS for Medicaid reimbursement.

The roommate must:
- complete and pass background checks, including criminal registry checks required by §§ 37.2-416, 37.2-506, and 37.2-607 of the Code of VA.
- successfully meet basic training requirements such as CPR training, safety awareness, fire safety and disaster planning, conflict management and resolution, or any other necessary specialized training defined in the individual's person-centered plan.

The administrative provider must ensure that there is a back-up plan in the event that the roommate is unable to provide supports.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS Quality Management Review (QMR) staff verifies that the roommate has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify the administrative provider's qualifications every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Skilled nursing is defined as part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. 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 nonnursing personnel. Skilled nursing services must be ordered by a physician or nurse practitioner and must be medically necessary. These 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.

Services listed in the supports plan must be within the scope of the States Nurse Practice Act and are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the Commonwealth of Virginia.

Skilled nursing services under the waiver differ in scope from skilled nursing services in the State plan. Skilled nursing services provided under the waiver are those that do not meet home health criteria of acute, time-limited care. Skilled nursing services under this waiver are available to individuals with serious medical conditions and complex health care needs, who require specific skilled nursing services ordered by a physician which cannot be accessed under the State Plan for Medical Assistance. These services must be necessary to enable an individual to live in a noninstitutional setting in the community and cannot be provided by nonnursing personnel. Services are provided in an individual's home or community setting, or both, on a regularly scheduled or intermittent need basis.

The allowable activities include:

1. Consultation, assistance to direct support staff, and nurse delegation of skilled tasks to DSPs in accordance with the Code of Virginia;
2. Training of family and other caregivers;
3. Monitoring an individual's medical status;
4. Administering medications and other medical treatment; or
5. Assurance that all items listed in 1 through 4 are carried out in accordance with the plan for supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

If an individual has skilled nursing needs that are short-term and intermittent in nature, the case manager must assist the individual in accessing home health services under the State Plan for Medical Assistance. The State Plan Home Health coverage provides short-term intermittent skilled nursing services for five visits without preauthorization. It must be accessed through a licensed home health agency that has a provider agreement with DMAS for skilled nursing services. Additional visits after the initial five visits require pre-authorization from DMAS preauthorization contractor.

If an individual has skilled nursing needs that are expected to be longer-term, but intermittent in nature, the case manager may assist the individual in accessing skilled nursing services under the waiver.

Skilled nursing is billed in 15 minute units and is limited to 21 hours per week under the waiver. Individuals who require more than 21 hours per week of nursing services shall be encouraged to request service authorization for Private Duty Nursing. Skilled nursing may not be authorized or billed concurrently with private duty nursing except if nurse delegation activities through Skilled Nursing are required by the individual as indicated in the individual's ISP.

Foster care providers shall not be the skilled nursing services providers for the same individuals for whom they provide foster care.

Skilled nursing shall not be reimbursed while the individual enrolled in the waiver is receiving emergency care or is an inpatient in an acute care hospital or during emergency transport of the individual to such facilities.

In accordance with the CMS Informational Bulletin issued on July 7, 2014, skilled nursing for individuals under age 21 shall be accessed through the state plan pursuant to ESPDT. Skilled nursing through this waiver shall not be available to individuals under age 21.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Skilled Nursing Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Skilled Nursing Services Provider

Provider Qualifications

License *(specify):*

Skilled nursing services may be provided by either

1) a licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN employed by a DMAS-enrolled home health provider, or
2) a licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN who is contracted with or employed by a DBHDS-licensed DD provider day support, respite, or residential services.

The RN or LPN must have a current license issued by the Virginia Board of Nursing or a current multi-state licensure privilege to practice nursing in the Commonwealth as an RN or LPN, as applicable.

Relatives and legal guardians may provide this service, provided they meet all of the same provider requirements as those who are not relatives nor legal guardians.

Certificate *(specify):*

Other Standard *(specify):*

Skilled nursing providers must have a signed provider participation agreement with DMAS in order to provide skilled nursing services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers that have a DMAS participation agreement to provide home health services or a DMAS-enrolled Home Care Organization (HCO) may provide skilled nursing services under that agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Health Professions verifies credentials of registered nurses and licensed practical nurses.

The Virginia Department of Medical Assistance Services verifies provider qualifications.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of skilled nursing providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Sponsored Residential

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Sponsored Residential Services shall consist of skill-building, routine supports, general supports, and safety supports, provided in a 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 sponsored residential support services that are included in the individual's approved person-centered plan.

Sponsored residential services shall be authorized for Medicaid reimbursement in the person-centered plan 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.

Sponsored residential services to the individual in the form of continuous (up to 24 hours per day) services performed by the sponsor family who shall be physically present in the home. These supports may be provided individually or simultaneously to up to two individuals living in that home, depending on the required support.

Sponsored residential support includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

The allowable activities include, but are not limited to:

1) Skill-building related to personal care activities (toileting, bathing, and grooming; dressing; eating; mobility; communication; household chores; food preparation; money management; shopping, etc.);

2) Skill-building related to the use of community resources (transportation, shopping, dining at restaurants, participating in social and recreational activities, etc.);

3) Supporting the individual in developing the ability to replace challenging behavior with positive, accepted behavior for home and community environments, for example (not all inclusive):

- Developing a circle of friends;

- Handling social encounters with others; or

- Redirecting challenging behavior.

4) Monitoring health and physical conditions and providing supports with medication or other medical needs;

5) Providing supports with personal care, ADLs, and use of community resources, for example (not all-inclusive):

- Completing personal care or mealtime tasks when physically unable to do so; or

- Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the individual's health and welfare

6) Supporting with transportation to and from training sites and community resources;

7) Providing general supports as needed; and

8) Providing safety supports to ensure the individual's health and safety.

There is a small cohort of individuals (particularly individuals being discharged from the Training Center who are extremely medically fragile and/or behaviorally challenged), for whom customized rates will be necessary.

INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:
Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs fall outside of the supports that are available and funded through the standard rate for their assigned reimbursement tier. These individuals have exceptional medical and/or behavioral support needs and require 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them. These individuals may require higher level supports in order to avoid placement in a state operated mental health or DD facility, or in a more restrictive environment. They are often identified as those who require greater support in order to find in-state providers willing to serve them.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports. In addition, these individuals may require the supervision and oversight required by more experienced/highly trained direct support staff or require clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service

settings.

Medically, an individual may require 1:1 or 2:1 staff support when they have a health history or recent health complication that puts them at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during mealtime due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that they may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff may be necessary during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is a day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Sponsored Residential provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Sponsored Residential

Provider Category:

Agency

Provider Type:

Sponsored Residential provider

Provider Qualifications

License *(specify)*:

An agency licensed by DBHDS as a provider of DD sponsored residential home services.

Certificate *(specify)*:

Other Standard *(specify)*:

Sponsored Residential providers must have a signed provider participation agreement with DMAS in order to provide residential services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Sponsored residential settings shall comply with the HCBS settings requirements per 42 CFR 441.301. In these settings,

lease or residency agreements shall comply with and support

Providers must also assure that persons providing residential services have received training in the characteristics of I/DD and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing Community Living waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of DD Sponsored Residential services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced and announced onsite and desk reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of residential providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported living is residential supports that take place in a residential setting operated by a DBHDS licensed provider. These services shall consist of skill-building, routine supports, general supports, and safety supports, 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 supported living services that are included in the individual's approved person-centered plan.

Supported Living services shall be authorized for Medicaid reimbursement in the person-centered plan 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.

Supported Living services are provided to the individual in the form of 'round-the-clock availability of staff services performed by paid staff who have the ability to respond in a timely manner. These supports may be provided individually or simultaneously to more than one individual living in the residence, depending on the required support.

Supported Living includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

The allowable activities are:

1) Skill-building related to personal care activities (toileting, bathing, and grooming; dressing; eating; mobility; communication; household chores; food preparation; money management; shopping, etc.);

2) Skill-building related to the use of community resources (transportation, shopping, dining at restaurants, participating in social and recreational activities, etc.);

3) Supporting the individual in developing the ability to replace challenging behavior with positive, accepted behavior for home and community environments, for example (not all inclusive):

- Developing a circle of friends;

- Handling social encounters with others; or

- Redirecting challenging behavior.

4) Monitoring health and physical conditions and providing supports with medication or other medical needs;

5) Providing supports with personal care, ADLs, and use of community resources, for example (not all-inclusive):

- Completing personal care or mealtime tasks when physically unable to do so; or

- Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the individual's health and welfare

6) Supporting with transportation to and from training sites and community resources;

7) Providing general supports as needed; and

8) Providing safety supports to ensure the individual's health and safety.

There is a small cohort of individuals for whom customized rates will be necessary.

INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:
Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs fall outside of the supports that are available and funded through the standard rate for their assigned reimbursement tier. These individuals have exceptional medical and/or behavioral support needs and require 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them. These individuals may require higher level supports in order to avoid placement in a state operated mental health or DD facility, or in a more restrictive environment. They are often

identified as those who require greater support in order to find in-state providers willing to serve them.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports. In addition, these individuals may require the supervision and oversight required by more experienced/highly trained direct support staff or require clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.

Medically, an individual may require 1:1 or 2:1 staff support when they have a health history or recent health complication that puts them at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during mealtime due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that they may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff may be necessary during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is a day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

An agency licensed by DBHDS as a provider of DD supervised living residential services or DD supportive in-home services.

Certificate *(specify):*

Other Standard *(specify):*

Providers must have a signed provider participation agreement with DMAS in order to provide supported living services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers must also assure that persons providing Supported Living services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing waiver services and pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that providers of supported living services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced and announced onsite and desk reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of residential providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Therapeutic Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy

Category 3: 10 Other Mental Health and Behavioral Services

Sub-Category 3: 10040 behavior support

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Therapeutic consultation is professional consultation designed to assist the individual and the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver.

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. 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 Individual Support Plan 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.

The allowable activities are:

1. Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation either in-person or via telehealth platforms;

2. Observing the individual in daily activities and natural environments;

3. Assessing the individual's need for an assistive device or modification and/or adjustment in the environment or services, which may include some assessment elements conducive to telehealth platforms;

4. Developing data collection mechanisms and collecting baseline data;

5. Observing and assessing current interventions, support strategies, or assistive devices being used with the individual;

6. Designing a written support plan detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes; this may include recommendations related to specific devices, technology or adaptation of other training programs or activities;

7. Demonstrating specialized, therapeutic interventions, individualized supports, or assistive devices;

8. Training family/caregivers and other relevant persons to assist the individual in using an assistive device, to implement specialized, therapeutic interventions or adjust currently utilized support techniques, which may (if appropriate) include some training elements conducive to telehealth platforms;

9. Training relevant persons to better support the individual simply by observing the individual's environment, daily routines and personal interactions;

10. Reviewing documentation and evaluating the efficacy of assistive devices or the activities and interventions identified in the support plan;

11. In addition to the above, Behavior Consultation Services may include direct behavioral interventions and demonstration to family members/staff of such interventions. Intervention modalities shall relate to the individual's identified behavioral need. Specific goals and procedures for the Behavioral Services must be established;

12. Consulting related to person centered therapeutic outcomes, in person, over the phone, or via video feed consistent with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. The activities allowed to be performed via telehealth are meant to assist the individual in developing a plan and supports so that the individual can achieve greater community engagement and integration. Actual community engagement does not occur within this service. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service shall be one hour.

Therapeutic consultation may not include direct therapy provided to waiver individuals other than Behavioral Consultation.

Therapeutic consultation services may not duplicate the activities of other services available to the individual through the State Plan. In particular, the case manager must first access consultation from physical therapists, occupational therapists, speech and language therapists through the State Plan when State Plan services are available to an individual.
The services under the Community Living waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Therapeutic consultation shall not be solely for purposes of monitoring the individual.

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.

Allowable activities that can be performed using telehealth can be performed for up to 100% of the service hours.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Therapeutic Consultation Provider
Agency	Therapeutic Consultation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Therapeutic Consultation

Provider Category:

Individual

Provider Type:

Therapeutic Consultation Provider

Provider Qualifications

License *(specify):*

To provide Medicaid-funded therapeutic consultation, the person must be:

Psychology Consultation:

a. A psychologist who is licensed by the Commonwealth of Virginia; or

b. A licensed professional counselor who is licensed by the Commonwealth of Virginia;

c. A licensed clinical social worker who is licensed by the Commonwealth of Virginia;

d. A psychiatric clinical nurse specialist who is licensed by the Commonwealth of Virginia; or

e. A psychiatrist who is licensed by the Commonwealth of Virginia.

Behavior Consultation:

a. A licensed behavior analyst or licensed assistant behavior analyst; or

b. A positive behavior supports facilitator endorsed by a recognized positive behavior supports organization or who meets the criteria for psychology consultation.

Speech Consultation:
a Speech-Language Pathologist who is licensed by the Commonwealth of Virginia.

Certificate *(specify):*

To provide Medicaid-funded therapeutic consultation, the person must be:

Occupational Therapy Consultation:
An occupational therapist who is licensed by the Commonwealth of Virginia.

Physical Therapy Consultation:
A physical therapist who is licensed by the Commonwealth of Virginia.

Therapeutic Recreation Consultation:
A therapeutic recreation specialist who is certified by the National Council for Therapeutic Recreation Certification

Rehabilitation Engineer Consultation:
A rehabilitation engineer or certified rehabilitation specialist.

Other Standard *(specify):*

Therapeutic consultation providers must have a signed Provider Participation agreement with DMAS in order to provide therapeutic consultation services. The provider designated in the Participation Agreement must directly provide the services

and bill DMAS for Medicaid reimbursement.

An individual consultant with the necessary qualifications may obtain a DMAS Participation Agreement or be employed by or contracted with a provider with a Participation Agreement to provide the services.

Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

Verification of Provider Qualifications

Entity Responsible for Verification:

Virginia Department of Health Professions verifies individual credentials for Speech-Language Pathologists, psychiatrists, clinical nurse specialists, licensed clinical social workers, licensed professional counselors, psychologists, occupational therapists, physical therapists and board-certified behavior analysts/associate behavior analysts.

The Endorsement Board through the Partnership for People with Disabilities at Virginia Commonwealth University or other recognized PBSF training organization assures the qualifications of Positive Behavior Support Facilitators.

The Virginia Department of Medical Assistance Services verifies provider qualifications.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of therapeutic consultation providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Therapeutic Consultation

Provider Category:

Agency

Provider Type:

Therapeutic Consultation Provider

Provider Qualifications

License *(specify):*

To provide Medicaid-funded therapeutic consultation, the person must be:

Psychology Consultation:

a. A psychologist who is licensed by the Commonwealth of Virginia; or

b. A licensed professional counselor who is licensed by the Commonwealth of Virginia;

c. A licensed clinical social worker who is licensed by the Commonwealth of Virginia;

d. A psychiatric clinical nurse specialist who is licensed by the Commonwealth of Virginia; or

e. A psychiatrist who is licensed by the Commonwealth of Virginia.

Behavior Consultation:

a. A licensed behavior analyst or licensed assistant behavior analyst; or

b. A positive behavior supports facilitator endorsed by a recognized positive behavior supports organization or who meets

the criteria for psychology consultation.

Speech Consultation:
a Speech-Language Pathologist who is licensed by the Commonwealth of Virginia.

Certificate *(specify):*

To provide Medicaid-funded therapeutic consultation, the person must be:

Occupational Therapy Consultation:
An occupational therapist who is licensed by the Commonwealth of Virginia.

Physical Therapy Consultation:
A physical therapist who is licensed by the Commonwealth of Virginia.

Therapeutic Recreation Consultation:
A therapeutic recreation specialist who is certified by the National Council for Therapeutic Recreation Certification

Rehabilitation Engineer Consultation:
A rehabilitation engineer or certified rehabilitation specialist.

Other Standard *(specify):*

Therapeutic consultation providers must have a signed provider participation agreement with DMAS in order to provide therapeutic consultation services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

An individual consultant with the necessary qualifications may obtain a DMAS participation agreement or be employed by or contracted with a provider with a participation agreement to provide the services.

Providers that choose to render allowable activities via telehealth must adhere to the requirements of their provider agreement to meet all state and federal requirements including HIPAA. The Virginia Department of Medical Assistance Services (DMAS) Provider Application v1.2 states "The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).".

Verification of Provider Qualifications

Entity Responsible for Verification:

Virginia Department of Health Professions verifies individual credentials for speech-language pathologists, psychiatrists, clinical nurse specialists, licensed clinical social workers, licensed professional counselors, psychologists, occupational therapists, physical therapists and board-certified behavior analysts/associate behavior analysts.

The Endorsement Board through the Partnership for People with Disabilities at Virginia Commonwealth University or other recognized PBSF training organization assures the qualifications of Positive Behavior Support Facilitator.

The Virginia Department of Medical Assistance Services verifies provider qualifications.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DMAS QMR staff review a sample of therapeutic consultation providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transition services are nonrecurring set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable costs are:

a. Security deposits that are required to obtain a lease on an apartment or home;
b. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens;
c. Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;
d. Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
e. Moving expenses;
f. Fees to obtain a copy of a birth certificate or an identification card or driver's license; and
g. Essential clothing items.

Transition services are furnished only to the extent that they are reasonable and necessary as determined and clearly identified in the service plan, and the person is unable to meet such expenses or when the services cannot be obtained from another source. Transition services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household items that are intended for purely diversional/recreational purposes. This service does not include services or items that are covered under other waiver services such as environmental modifications or assistive technology.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services shall be available for one transition per individual and shall be expended within nine months from the date of authorization.

The total cost of these services shall not exceed $5,000, per-person lifetime limit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Transition Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers shall be enrolled as a Medicaid provider of Transition Services and work with DMAS or its designated agent to receive reimbursement for the purchase of appropriate transition goods or services on behalf of the individual.

Providers may also go through the CSB's Organized Healthcare Delivery System (OHCDS) as a provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Workplace Assistance Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Workplace Assistance services are supports provided to someone who has completed job development and completed or nearly completed and job placement training (i.e., supported employment) but requires more than typical job coach services to maintain stabilization in their employment.

Workplace Assistance services are supplementary to the services rendered by the job coach; the job coach still provides professional oversight and job coaching intervention. This service is designed for those limited number of individuals who receive individual supported employment services who are unable to maintain employment following the fading of the job coach without ongoing supports on the job site. The intent is for those individuals to receive some level of ongoing support at the job site in the areas of social skills, communication, personal care (though this may not be the only reason for the provision of this service), attention to task, etc. These are all common skill areas which, if not properly supported, may result in an individual with developmental disabilities losing community employment. This service should not be for the development of actual job skills; that work should be completed by the job coach before fading and maintained by periodic contacts on the job site/with the employer. Areas of overlap are when the Workplace Assistant first begins working with the individual (the job coach will need to show him/her the parameters of the job and discuss the individual's needs) and during the periodic visits by the job coach back to the job site (after fading) to ensure that all is still going well with the employment situation. Workplace assistance will not necessarily be billed for the entire time (hours per day) that the individual is working; it may be needed during certain critical parts of the day. However, it may be of a long-term nature and not subject to fading.

The provider provides on-site habilitative supports related to behavior, health, time management or other skills that otherwise would endanger the individual's continued employment. The provider is able to support the person related to personal care needs as well; however, this cannot be the sole use of Workplace Assistance services.

In order for an activity to qualify under Workplace Assistance services it must include all four of the following:

1. The activity must not be work skill training related which would normally be provided by a job coach
2. Services are delivered in their natural setting (where and when they are needed)
3. Services must facilitate the maintenance of and inclusion in an employment situation
4. The ratio is 1:1

Allowable activities include:

1. Habilitative supports related to nonwork skills needed for the individual to maintain employment such as appropriate behavior, health maintenance, time management, or other skills without which the individual's continued employment would be endangered;
2. Habilitative supports needed to make and strengthen community connections;

3. Routine supports with personal care needs alongside other activities within this service;
4. Safety supports needed to ensure the individual's health and safety.

If the individual experiences behavioral health and/or behavioral support challenges, elements of skill building and supports around non-work skills can be utilized and addressed via a HIPAA-compliant telehealth platform when the individual's need for support is critical to maintaining employment. Any activity of this nature delivered via telehealth must be clearly documented in the ISP.

There is no specified minimum for in-person visits when the individual's plan for supports specifies that telehealth is a permissible model of delivery; however, no more than 10% of the available service hours may be conducted via telehealth and only the activities as listed above may be done through telehealth. Any individual who uses telehealth for this service shall have his/her privacy respected while ADLs are being performed as ADL support is not an allowable activity for this service. The use of telehealth in this service is meant to supplement and not supplant the individual's community integration. The ability for individuals to connect with providers via a HIPAA-compliant remote platform offers the individual the opportunity to prepare, to plan, and to perform the telehealth-allowed activities to enhance the individual's community integration opportunities in a lower stress environment for the individual. Providers are required to assess the individual prior to requesting using telehealth as an allowable service of delivery. Justification for telehealth as an appropriate service modality must be included in the individual's person-centered service plan. The justification should assess and document the individual's ability to be supported effectively via a telehealth platform during allowable activities. If an individual requires the provider's in-person presence and physical assistance from the provider during an activity delivered through telehealth, telehealth may not be an appropriate method for which successful delivery of services may be provided and an in-person option must be provided. As part of the provider's assessment of the individual's ability to use telehealth, the provider must also have information available to the individual, family, and/or unpaid caregiver on how to access and to utilize the provider's telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology service, provided appropriate criteria apply. Any provider of this service who delivers allowable activities via a telehealth modality is still required to report all suspected abuse, neglect, and/or exploitation immediately as a mandated reporter. The State acknowledges that telehealth does not substitute in-person health, safety, and welfare guards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is an hour. Workplace Assistance services, alone or in combination with Community Engagement, Community Coaching, Group Day, and/or Supported Employment services are limited to no more than 66 hours per week.

This service can be provided during the time the individual being served is working, up to and including 40 hours a week. There is no time limit on how long these services can remain authorized.

When both the individual and the WPA provider (as agreed upon by all parties) are utilizing telehealth platforms, the utilization of telehealth shall not exceed 10% of the authorized and billed units per month.

This service may not be provided simultaneously with on-the-job Personal Assistance services, nor may Workplace Assistance services be provided solely for the purpose of provision of assistance with ADLs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Workplace Assistance provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Workplace Assistance Services

Provider Category:

Agency

Provider Type:

Workplace Assistance provider

Provider Qualifications

License *(specify):*

Providers shall be DARS-contracted providers of supported employment services.

OR

possess a DBHDS DD non-center based day support services license.

Certificate *(specify):*

Other Standard *(specify):*

Workplace Assistance providers must have a signed provider participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The staff person providing Workplace Assistance services must have completed training regarding the principles of supported employment and coordinate with the job coach providing Individual Supported Employment to the individual being supported.

Workplace Assistance may not be provided only for purposes of Personal Assistance.

Verification of Provider Qualifications

Entity Responsible for Verification:

DARS verifies that vendors of supported employment services meet criteria to be a vendor through a DARS-recognized accrediting body or DBHDS Office of Licensing verifies that providers of DD non-center-based Day Support services meet DBHDS licensing standards.

DMAS Quality Management Review (QMR) staff verifies that staff has received the required training.

Frequency of Verification:

The Virginia Department of Medical Assistance Services will verify provider qualifications every two years.

DBHDS Office of Licensing staff may conduct unannounced or announced onsite or desk reviews of licensed providers and each of its services at any time and at least annually to determine compliance with licensing regulations. Staff may investigate complaints or incidents to determine if there is a licensing violation.

DMAS QMR staff review a sample of supported employment providers annually. Staff may conduct announced and unannounced onsite reviews at any time.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver

participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ● **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☑ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Targeted case management services as a State Plan Option service for all individuals receiving waiver services are provided through the local CSBs with oversight and licensing by DBHDS. The service may be provided directly by CSB staff or by private case managers through a contractual arrangement with a particular CSB that bills for and monitors the service.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ● **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Per §37.2-416, §37.2-506 and §37.2-607 of the Code of Virginia, every DBHDS-licensed provider shall require any applicant who accepts employment as a direct support professional (any position that includes responsibility for service provision, case management, health, safety, development, or well-being of an individual) or as the immediate supervisor of a person in a position with this responsibility to submit to fingerprinting and provide personal descriptive information to be forwarded through the Central Criminal Records Exchange to the Federal Bureau of Investigation (FBI) for the purpose of obtaining national criminal history record information regarding the applicant. No provider licensed to provide supports to individuals with developmental disabilities shall hire for compensated employment persons who have been convicted of any offense listed in subsection B of § 37.2-314 of the Code of Virginia. The Central Criminal Records Exchange, upon receipt of an individual's record or notification that no record exists, shall submit a report to the requesting licensed provider.

Per §37.2-408.1 of the Code of Virginia, every children's residential facility that is regulated or operated by the DBHDS shall require any employee, regular volunteer or contractor who will be alone with a juvenile in the performance of his duties to submit to fingerprinting and to provide personal descriptive information, to be forwarded along with the applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant.

The state agency shall report to the children's facility whether the applicant is eligible to have responsibility for the safety and well-being of children. No children's residential facility regulated or operated by the Department shall hire for compensated employment or allow to volunteer or provide contractual services persons who have been convicted of or are the subject of pending charges for crimes detailed in §37.2-408.1.

All agency providers must also demonstrate the completion of criminal records checks as a part of the enrollment process for a DMAS Provider Participation Agreement. All agency providers not licensed by DBHDS must demonstrate that the Criminal History Records Check has been completed as part of QMR conducted by DMAS. DMAS requires that criminal background checks be requested to the Virginia State Police prior to the start of employment with additional supervision provided to the employee until the records check results are received, typically within several days.

For consumer-directed services, the contracted FMS agent is responsible for conducting Virginia State Police criminal records checks for all consumer directed employees and this process is ensured by the DMAS contract monitor.

Additionally, for Employment and Community Transportation, providers must ensure that staff are not listed on the Virginia Sex Offender Registry. Each employee must complete an attestation signed by the private driver, the individual, and the individual's guardian or authorized representative (as appropriate) that the driver has disclosed any relevant felonies and whether he or she is listed on any registry.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ● **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Virginia Department of Social Services (VDSS) maintains a Child Protective Services Abuse Registry, which is a registry of founded complaints of child abuse and neglect. Screenings via this registry must be completed for personal and respite assistants and companions, as well as for DBHDS-licensed providers on each direct support professional (as specified in the Administrative Code of Virginia at 12 VAC 35-105-400). The DBHDS Office of Licensing is responsible for ensuring that Child Protective Services (CPS) registry checks have been completed as a part of the annual licensing process. DMAS QMR provides follow-up monitoring.

All other agency providers not licensed by DBHDS must demonstrate that CPS registry checks have been completed for staff supporting minors as a part of QMR conducted by DMAS. All agency providers must also demonstrate the completion of CPS registry checks for staff supporting minors as a part of the enrollment process for a DMAS provider participation agreement.

For consumer-directed services, the contracted FMS agent is responsible for conducting CPS registry checks for those employees who will be working with children. This process is verified by the DMAS contract monitor.

DMAS requires that CPS registry checks be requested prior to the start of employment with additional supervision provided to the employee until the records check results are received.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ● **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Legally responsible individuals (LRIs) may provide personal assistance services. Legally responsible individuals are defined as parents or legal guardians of minors or the participant's spouse. Personal assistance services provided by a legally responsible individual must be extraordinary in nature, which is above and beyond what they are obligated to provide. Personal assistance may only be used to meet the extraordinary needs of the participant under the age of 18 due to his or her disability, and it is above and beyond the typical basic care for a child that all families with children of the same age may experience. For individuals younger than 18 years of age, the LRI must meet the needs of the participant, including the need for assistance and supervision typically required for children at various stages of growth and development.

Reimbursement may be made to LRIs for up to 40 hours per week. When the LRI is reimbursed to provide assistance for multiple children, they may be reimbursed for up to 40 hours per week for each child.

The LRI must also meet the same requirements as other personal assistance aides or attendants. LRIs convicted of a barrier crime, as defined in the Code of Virginia, are ineligible to be paid providers of services. All services rendered by a paid LRI must be within the scope of the personal assistance service and are limited to support with Activities of Daily Living (ADLs). Instrumental Activities of Daily Living (IADLs) and general supervision are not considered extraordinary care. A Registered Nurse must delegate skilled tasks in accordance with the Virginia Administrative Code 18 VAC 90-19-240 et seq. and Code of Virginia § 54.1-3001(12) otherwise the skilled tasks will not be reimbursed Further, respite is not available when there is a paid LRI, as respite is for the relief of the unpaid primary caregiver.

Provider agency supervisors and CD services facilitators (until 5/31/27) and/or support broker (starting 3/1/27) have oversight responsibility to ensure that services are being rendered according to the Plan of Care and that billing only occurs for services rendered. Further, DMAS Quality Management Review and other DMAS staff will compare documentation of service delivery with the individual's Plan of Care and compare these against payments made to ensure payments are made only for services rendered.

The RN agency supervisor/CD services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) and MCO care coordinator/CSB case manager must monitor the situation to ensure that the individual's growth towards independence is not hindered by having a LRI as a paid support person and that the LRI remains aware that there is a different relationship once he/she becomes a paid employee to support the individual.

When the consumer-direction model is used, the Employer of Record (EOR), who is responsible for the direct oversight of services and approves all attendant work shifts for payment, may be another LRI, including a parent or step-parent. Under consumer direction, the following requirements must be met to ensure the services are in the best interest of the participant and to ensure payments are made only for services rendered:

1. Individuals must choose a services facilitator (until 5/31/27) and/or support broker (starting 3/1/27);
2. The DMAS-95B ("Consumer-Direction Services Management Questionnaire") must be completed and assessed prior to service authorization;
4. The LRI must document all tasks for each shift through a DMAS-approved method.

On-site, face-to-face monitoring of services by LRIs will be performed by the agency RN, Services Facilitator (until 5/31/27) and/or support broker (starting 3/1/27), or a licensed DBHDS provider agency's supervisor at least every 90 days. The state will also conduct targeted quarterly reviews at the participant's home to ensure that the LRIs are providing care in the best interest of the individual and that they meet the needs of the individual.

In DMAS will require providers to document the need for extraordinary care during the person-centered planning process. To ensure the extraordinary care documentation is completed, DMAS will develop an LRI plan of care and assessment form that will be used during service authorization. While this form is under development, DMAS will require providers to document this information in the individual's record. . The nurse supervisor (for agency-directed services) or Services Facilitator (until 5/31/27) and/or support broker (starting 3/1/27) (for consumer-directed services) and will identify the individual's extraordinary support needs with Activities of Daily Living (ADLs) with the waiver individual, family, consumer-directed EOR, and any other parties as desired.

The extraordinary care documentation requirements will include:

- The types of tasks requiring support
- The time to complete each task per day
- Whether the task is typical care that would be needed based on the age and development of the individual

Tasks that are not extraordinary in nature will not be approved or reimbursed. Additionally, LRI caregivers will not be reimbursed to provide instrumental ADLs or supervision. Guidelines for extraordinary care will be based on the chronological age of the individual and needs that are beyond those typically required.

Should an individual hire an additional non-LRI attendant to provide additional personal assistance support, an additional Plan of Care will be developed. The non-LRI Plan of Care and LRI Plan of Care will work in tandem to address the waiver individual's daily needs. To receive service authorization, the personal assistance agency/Services Facilitator (until 5/31/27) and/or support broker (starting 3/1/27) must submit both the LRI Plan of

Care and the non-LRI Plan of Care together.
The State requires assurances that the waiver individual's wants and needs are first and foremost in service planning and in continuous evaluation of the appropriateness of this service provider arrangement. To ensure the waiver individual's opinions-to the extent practicable-are shared with others, all service plan development meetings and assessments of the LRI Plan of Care are required to occur face-to-face with the waiver individual present. When the waiver individual has the capacity to communicate their thoughts and opinions, just as with the development of all service plans, time must be made to discuss with the waiver individual this service arrangement to include their satisfaction with the services, the available models, and options of care in personal assistance services, and the waiver individual's preferred choice in services.
The LRI plan of care form will include an attestation from the waiver individual that this is his/her choice of services and service provider and a signature page for all planning team members to sign.
In addition, there is an additional attestation from the nurse supervisor/Services Facilitator (until 5/31/27) and/or support broker (starting 3/1/27) that they agree that the waiver individual has been offered the opportunity to express his/herself to the fullest of his/her ability and that this arrangement of care is what the waiver individual has chosen.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ● **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

The following services may be rendered by a relative or legal guardian (provided they meet all requirements): Community Coaching, Community-Directed Services Facilitation (until 5/31/27), Companion Services, Employment and Community Transportation, Group Day Services, Group Home Residential, Group Supported Employment, Individual Supported Employment, In-Home Supports, Personal Assistance, Private Duty Nursing, Respite, Skilled Nursing, Sponsored Residential, Supported Living, and Workplace Assistance. Relatives, but not legal guardians, are also permitted to provide Shared Living Residential, provided they meet all requirements.

Family members and legal guardians living under the same roof as the individual being served may not provide services unless there is objective written documentation as to why there are no other providers available to provide the services. This does not apply to legally responsible individuals. Family members and legal guardians who provide these services must meet the same standards as providers who are unrelated to the individual and no additional limitations exist regarding the amount of services that may be furnished by these family members or legal guardians. Examples of situations meeting the criteria of no other providers available might include:

- individuals living in a remote area unserved or underserved by other providers;
- individuals with documented complex medical or behavioral needs, which do not require skilled nursing services in nature, which are best met by the family member or legal guardian;
- individuals who require services at hard-to-staff hours; or
- numerous providers have been unsuccessful at appropriately supporting the individual
- numerous providers have assessed the situation and responded in writing that they cannot provide services.

This information shall be documented in the individual's person-centered support plan that service delivery by the family member or legal guardian best meets the individual's preferences and support needs, and that the individual's choice of providers has been honored. Concerns that these intents will not or have not been fulfilled should be discussed with DBHDS staff.
Provider agency supervisors (or the CD services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) in the case of consumer-directed services), have an oversight responsibility to ensure that services are being rendered according to the support plan and that billing occurs only for documented services rendered. Further, DMAS Quality Management Review staff compare documentation of service delivery with the individual's support plan and compare these against payments made to ensure payments are made only for services rendered. Both the individual's case manager/support coordinator and QMR staff interview individuals themselves as part of their oversight efforts and ask questions about their receipt of and satisfaction with services.

If the case manager/support coordinator does not feel that it is in the best interest of the individual for a certain family member or legal guardian to be a paid service provider, it is his/her responsibility to address this. The case manager/support coordinator must verify that one of the above situations or another equally serious extenuating circumstance exists that necessitates a family member or legal guardian being a provider (i.e., slot assignment information included references to the family's inability to care for the individual). The case manager/support coordinator must monitor the situation to ensure that the individual's growth toward independence is not hindered by having a family member or legal guardian as a paid support person and that the family member or legal guardian remains aware that there is a different relationship once he/she is paid to support the individual.

Case managers/support coordinators also have recourse to DBHDS service authorization staff in the form of relaying their concerns. DBHDS staff will review the information submitted and make a determination as to whether or not authorizing a particular person as paid caregiver should or should not occur. As for all staff supporting individuals in this waiver, if a family member/legal guardian has committed a "barrier crime" as defined in Virginia Code, he or she is ineligible to be a paid provider of services.

All waiver services must be authorized prior to delivery by DBHDS service authorization staff who review and compare individual's assessment information and their ISP outcomes/support activities. Staff authorize services which are in compliance with regulations and in accordance with the individual's needs (inclusive of best interests). Therefore, providers may not bill for services beyond the limits which are authorized. DMAS Quality Management Review and Provider Integrity staff conduct look behinds to ensure that, for a sample of waiver participants, payment is in accord with documentation of service delivery.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

All providers may enroll via telephone, postal mail, or web-based contact with the Department of Medical Assistance Services and its contractor for provider enrollment. There is no fee for provider application or enrollment. Interested providers submit an application and supporting documentation to DMAS' Provider Enrollment Unit, who processes the application and issues a provider enrollment number within 15 business days.

All provider enrollment information is available on the DMAS Web portal and available to the general public.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

  *And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP2. Number & percent of licensed/certified provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results. N: Number of licensed/certified provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results. D: Total # licensed/certified provider agency staff records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP1. # & % of licensed/certified waiver agency provider enrollments for which the appropriate lic/cert was obtained in accordance with waiver requirements prior to service provision N:# of lic/cert waiver agency provider enrollments for which the appropriate lic/cert was obtained in accordance with waiver reqs prior to service provision D: Total # of lic/cert waiver agency provider enrollments

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment Records

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP3. Number & percent of enrolled licensed/certified provider agencies continuing to meet applicable licensure/certification following initial enrollment. N: Number of enrolled licensed/certified provider agencies continuing to meet applicable licensure/certification following initial enrollment. D: Total number of enrolled licensed/certified provider agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP5. Number and percent of new consumer-directed employees who have a criminal background check at initial enrollment. N: # of new consumer-directed employees who have a criminal background check at initial enrollment. D: total # new consumer directed employees enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Employer Agent Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other**	☐ **Annually**	☐ **Stratified**

Specify: Fiscal Employer Agent		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP6. Number and percent of consumer-directed employees with a failed criminal background check that are barred from employment. N: # of consumer-directed employees who have a failed criminal background who are barred from employment. D: total # consumer-directed employees who have a failed criminal background check.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Fiscal Employer Agent Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Employer Agent	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP4. Number and percent of enrolled services facilitation providers who meet waiver provider qualifications. N: #of enrolled services facilitation providers who meet waiver provider qualifications. D: total # enrolled services facilitation providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Provider Enrollment contractor	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP7: Number and percent of non-licensed/non-certified provider agencies that meet waiver provider qualifications. N: # of non-licensed/non-certified provider agencies that meet waiver provider qualifications. D: total # of non-licensed/non-certified waiver provider agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment Reports

Responsible Party for data collection/generation*(check*	**Frequency of data collection/generation***(check*	**Sampling Approach** *(check each that*

each that applies):	*each that applies):*	*applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Provider enrollment contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP8. Number and percent of provider agency staff, hired within 365 days of start date of QMR, meeting provider orientation training requirements. N: Number of provider agency staff, hired within 365 days of start date of QMR, meeting provider orientation training requirements. D: Total number of provider agency staff, hired within 365 days of start date of QMR, reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Universe = staff names encountered during record review 50 employees and below -100% 51 employees and above - representative sample 95/5
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP9. Number and percent of provider agency direct support professionals (DSPs) with "proficiency confirmed", as part of the staff competency training requirements. N: Number of provider agency DSPs with proficiency confirmed as part of the staff competency training requirements. D: total number of provider agency DSPs records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify:

		Universe=staff names encountered during record review 50 employees and below -100% 51 employees and below-representative sample 95/5
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP10. Number and percent of services facilitation providers meeting training

requirements and passing competency testing as specified in state regulation. N: Number of services facilitation providers meeting training requirements and passing competency testing as specified in state regulation. D: Total number of services facilitation providers reviewed.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Virginia Commonwealth University	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DMAS QMR staff identifies problems with any of the above measures for a given provider. They each require a corrective action plan to be developed and implemented by that provider. Failure to do so jeopardizes the provider's license/Medicaid provider agreement. DMAS QMR staff follow up on all corrective action plans by reviewing records to ensure corrections have been made within 45 days. Serious violations may be referred to DMAS' Provider Integrity unit for billing retraction

Individual providers with systemic problems will be targeted for technical assistance/training from DBHDS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

1) The majority of supports and services are provided to the individual in the private and/or family home within the community. Settings where HCBS services are provided include:
a. Congregate Settings (Group Home and Sponsored Home Residential settings): Settings licensed via Virginia Department of Behavioral Health and Developmental Services based upon bed-size. The service shall consist of skill-building, routine supports, general supports, and safety supports that are provided to enable an individual to acquire, retain, or improve skills necessary to successfully live in the community
b. Private Homes: Personal (own, rent, lease, etc) residence of the person receiving supports. The individual is able to receive an array of HCBS services within the home including non-congregate residential services, personal care services, nursing services, and therapeutic consultative services.
c. Group Day Settings: Settings licensed via Virginia Department of Behavioral and Developmental Services that help the individual acquire, retain, or improve skills of self-help, socialization, community integration, career planning, and adaptation via opportunities for peer interactions, community integration, and enhancement of social networks. This service typically shall be offered in a nonresidential setting. Skill-building shall be a component of this service unless the individual has a documented progressive condition, in which case group day service may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills.
d. Employment settings: Department of Aging and Rehab Services (DARS)-contracted providers of supported employment service. DARS shall verify that these providers meet criteria to be providers through a DARS-recognized accrediting body.
e. Respite: May occur in either a licensed setting or private residence based upon the needs of the individual and/or the unpaid primary caregiver. Virginia has residential settings licensed to provide respite care if needed.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

The Commonwealth has embedded the HCB Settings criteria into existing state regulations for ongoing oversight and compliance. This includes the Department of Behavioral Health and Developmental Services' (DBHDS) Office of Licensing regulations and the Department of Medical Assistance Services' (DMAS) Developmental Disabilities waivers regulations.
The DBHDS Licensing regulations became effective on August 1, 2020. These regulations include the following language:
12VAC35-105-150. Compliance with applicable laws, regulations and policies.
The provider including its employees, contractors, students, and volunteers shall comply with:
1. This chapter;
2. The terms and stipulations of the license;
3. All applicable federal, state, or local laws and regulations including:
-Laws regarding employment practices including the Equal Employment Opportunity Act;
-The Americans with Disabilities Act and the Virginians with Disabilities Act;
-For home and community-based services waiver settings subject to this chapter, 42 CFR 441.301(c)(1) through (4);
-Occupational Safety and Health Administration regulations;
-Virginia Department of Health regulations;
-Virginia Department of Health Professions regulations;
-Virginia Department of Medical Assistance Services regulations;
-Uniform Statewide Building Code; and
-Uniform Statewide Fire Prevention Code.
4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board; and
5. The provider's own policies. All required policies shall be in writing.

Per licensing regulations, providers are responsible for compliance with HCBS settings requirements. In addition, providers are responsible for compliance with their own policies. This is significant because, to be compliant as an organization a provider must have an HCBS rights policy that includes: requirements for annual disclosures of HCBS rights to individuals/families and mandatory annual staff training on HCBS rights. Provider's HCBS policies have been reviewed by a member of the state team. For providers who were delivering services prior to 2018, a review of policy and practice was competed in the Research Electronic Data Capture (REDCap) secure website. Providers received direct feedback from a state reviewer on their HCBS policy and practices. As new providers enter the system, their policy is reviewed by a member of the state team before any provider is entered into the Medicaid network. A new provider is unable to enter the network without a letter of compliance that states the HCBS policy was reviewed and approved. This process is outlined in the assessment section of this plan (below).
The DMAS Developmental Disabilities waivers regulations became effective on March 31, 2021 and include the following language:
12VAC30-122-120. Provider requirements.
A. Providers approved for participation shall at a minimum perform the following activities:
7. Provide medically necessary services and supports for individuals in accordance with the ISP and in full compliance with 42 CFR 441.301, which provides for person-centered planning and other requirements for home and community-based settings including the additional requirements for provider-owned and controlled residential settings; Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.) .
The implementation of the requirements outlined in this regulation are included in the DMAS Quality Management Reviews (QMR). The purpose of QMRs is to monitor the provider's compliance with the Quality Assurances determined by the CMS and to ensure the health, safety and welfare of the members. Any violations of the criteria are included in a mandatory corrective action plan that is completed by the provider to ameliorate deficits that were identified in the review.
Virginia identified the support coordinator/case management entities as the first line of quality oversight in the waiver system. Support coordinators see individuals receiving services at least every 90 days and more frequently if their needs require more intensive oversight. The current Onsite Visit Tool used by support coordinators is completed each time they see an individual using services. This mandatory tool was modified in November 2022 to include specific questions related to a provider's ongoing HCBS compliance.
Lastly, both DBHDS and DMAS have the ability to refer providers with a history of non-compliance for mandatory provider remediation. This process, outlined below, requires a provider to complete mandatory retraining under supervision of state staff in order to maintain their provider participation agreement.

Providers with a history of noncompliance, which may include multiple records with citations of failure to comply with regulations or multiple citations related to health and welfare for one service plan, resulting in a corrective action plan or citation by either DMAS or DBHDS in key identified areas will be required to undergo mandatory training and technical assistance in the specific area(s) of noncompliance. These areas of noncompliance may include health, safety, or failure to address the identified needs of the individual. Failure to complete the mandatory training or identified technical assistance may result in referral to DMAS Program Integrity or termination of the provider's Medicaid participation agreement. 12VAC30-122-120.

Compliance & Monitoring of all settings:

New Providers

As outlined in the approved Statewide Transition Plan (STP), as of August 2018, all new providers are required to enter the system in full compliance with the HCB Settings Rule. In order for a potential provider to enroll with the Medicaid system, they must first complete an assessment and submit to DMAS all applicable policies and procedures for review. This assessment was included as an attachment with the Commonwealth's final STP. Providers receive direct feedback and one on one technical support for any noted deficiencies. In addition, this assessment is designed to ensure that a provider's HCBS policy becomes a part of their agency philosophy with specific questions regarding access to the community, choice, autonomy, independence, and an additional supplement for all provider owned and operated settings. Once a new provider's policies are deemed compliant, they are able to enter the Medicaid network. However, the setting then receives an unannounced visit from the DBHDS Office of Human Rights. This visit is a validation that HCBS has been fully implemented by the setting. Should any deficiency be noted, the provider is required to address the issue and once again receive a follow-up by the Office of Human Rights.

Existing Providers

For any existing provider as of 2018 a comprehensive assessment has been in place since 2018 (outlined in the STP). In addition, each setting across the Commonwealth is receiving a validation assessment by way of an onsite review, desk-audit or quality service review. Following any validation method, a provider is given a comprehensive summary of strengths and areas for improvement. If any specific HCBS violation was noted, the provider is required to complete a corrective action plan and submit evidence of remediation. This is an intensive effort on behalf of all stakeholders (state staff, case management and the provider community) where each setting receives a comprehensive validation review. These reviews include: interviews with individuals receiving services, interviews with staff, tours of settings, reviews of person-centered plans, and reviews of provider documentation.

These reviews have generated valuable insights for the state in terms of barriers to compliance, including the direct care workforce crisis. The state is working with the provider community and larger stakeholder community to look for solutions to this significant barrier. Additional information on the waiver infrastructure landscape was provided in the November 22, 2022 letter to CMS. The workforce crisis and public health emergency have significantly impeded the pace of each setting validation. The state has reviewed 40% of all the required settings. The commonwealth has surpassed the 400 onsite reviews that were identified in the STP, to date 458 onsite reviews have been completed. As each existing provider receives a comprehensive summary report of the findings and the ability to correct deficits, the average review spans 1-3 months. The Commonwealth anticipates reviewing all targeted settings and having all setting-specific remediation completed no later than January 1, 2026 (as outlined in the previous correspondence). As outlined above, HCBS specific criteria are re-evaluated on an ongoing basis by way of the standing oversight systems, the Office of Licensing, QMR Reviews, and Support Coordination/ Case Management Oversight.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***
- ☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☑ **Facilitates individual choice regarding services and supports, and who provides them.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

○ **No, the waiver does not include provider-owned or controlled settings.**

● **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☑ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☑ **Each individual has privacy in their sleeping or living unit:**

- ☑ **Units have entrance doors lockable by the individual.**
- ☑ **Only appropriate staff have keys to unit entrance doors.**
- ☑ **Individuals sharing units have a choice of roommates in that setting.**
- ☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☑ **Individuals have the freedom and support to control their own schedules and activities.**

☑ **Individuals have access to food at any time.**

☑ **Individuals are able to have visitors of their choosing at any time.**

☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application)*.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Support Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

ID and DD Targeted Case Management must be provided by a CSB or through a contractual arrangement between a CSB and a private provider. The CSB must be licensed by DBHDS as a provider of case management services and operate a 24-hour emergency services system.

A Participation Agreement to provide Targeted Case Management must be obtained from DMAS by the CSB. The CSB may directly operate Targeted Case Management Services or may contract with private agencies. If services are contracted, the CSB remains the responsible provider, and only the CSB may bill DMAS for Medicaid reimbursement.

An employee of a CSB or private provider, who provides ID or DD Targeted Case Management services, must possess a combination of work experience with persons with intellectual and/or other developmental disabilities and relevant education that indicates that he or she has the knowledge, skills, and abilities (KSAs) as established by DBHDS. These include:

- Knowledge of
1. Services and systems available in the community including primary health care, support services, eligibility criteria and intake processes and generic community resources;
2. The nature of developmental disabilities, mental illness, substance abuse (substance use disorders), or co-occurring disorders depending on the individuals served, including clinical and developmental issues;
3. Different types of assessments, including functional assessment, and their uses in service planning;
4. Treatment modalities and intervention techniques, such as behavior management, independent living skills building, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;
5. Types of developmental disabilities, mental health, and substance abuse programs available in the locality;
6. The person-centered service planning process and major components of a person-centered support plan;
7. The use of medications in the care or treatment of the population served; and
8. All applicable federal and state laws and regulations and local ordinances.

- Skills in
1. Identifying and documenting an individual's need for resources, services, and other supports;
2. Using information from assessments, evaluations, observation, and interviews to develop person-centered service plans;
3. Identifying and documenting how resources, services, and natural supports such as family can be utilized to promote achievement of an individual's personal life goals; and
4. Coordinating the provision of services by diverse public and private providers.

- Abilities to
1. Work as team members, maintaining effective inter- and intra-agency working relationships;
2. Work independently performing position duties under general supervision; and
3. Engage in and sustain ongoing relationships with individuals using services.

A person providing Targeted Case Management Services is not required to be a member of an organizational unit that provides only case management services. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, provide services as defined for Targeted Case Management services, and comply with service expectations and documentation requirements as required for organized case management units.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ● **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

CSBs, through the case management function, have a significant role in the development of the service plan. Some CSBs are also providers of certain waiver services (CSB waiver provider participation varies across the state). To mitigate influence, the following safeguards are in place:
- CSBs may be providers of waiver services, provided there is a separation of direct service provision units and case management units.
- If an individual selects a case manager employed by a private provider contracting with the local CSB, that entity may not provide any waiver services to the individual other than Services Facilitation (until 5/31/27).
- It is never permitted for a case manager (employed by a CSB or private provider) to be a direct support provider or supervise direct support providers of waiver services for individuals for whom he/she provides case management.

Each case manager must inform the individual and family member/caregiver, as appropriate, of the variety of services available through the waiver and offer choice among all providers serving the area in which the individual desires services. These two elements are documented on the "Documentation of Individual Choice between Institutional Care or Home and Community-Based Services" (Individual Choice) and the "Virginia Informed Choice" forms respectively, which are signed by the individual and family member/caregiver, as appropriate.

A completed Individual Choice form must be confirmed by DBHDS staff in the waiver management system in order to enroll an individual into the waiver. The presence of the Virginia Informed Choice form in the record is confirmed by CSB staff performing waiver record reviews. Data regarding these reviews is collected quarterly by DBHDS. Finally, DMAS Quality Management Review staff look for these two forms in each case management record reviewed and inquire about choice when conducting personal interviews with individuals/family members.

In addition to the above requirements supported by waiver regulations, the Performance Contract (mentioned in Appendix A) between DBHDS and each CSB states that the CSB agrees not to restrict or seek to influence the individual's choice among qualified service providers, although case managers may make recommendations, based on their professional judgment, to individuals regarding those available service options that best meet the needs and expressed desires documented in the individuals' ISP.

Case management services are available and provided through the Community Services Boards who are the only qualified providers as designated in the state plan. Only CSBs are charged with the responsibility of developing the services plan but in collaboration with the individual and his providers.

a. During the planning meetings, services are identified that best support the individual. When individuals are offered services, full disclosure of all available and willing providers of those designated services is offered and the individual's choice documented.

b. The state plan designated only qualified providers as those licensed for care management, which are the CSBs. CSBs offer choice of case management services by offering choice within agency when available, among other localities with whom they have agreements, and private providers when available.

c. Oversight and review of the assurance that choice of providers and services is conducted through the quality management review and program integrity process at the state Medicaid agency.

d. The state recognizes that CSBs are the only qualified providers of case management services and if they provide services within the locality, those services are maintained under separate divisions and administered by the CSBs. No case manager is allowed to develop the plan and also provide waiver services to the individual.

e. While some localities also provide waiver services within that locality, the case management and service provision units are administratively separate. Additionally, no case manage of an entity is allowed to provide services to that same individual whether with the locality or another provider to ensure a separation in roles.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the**

services furnished by the entity that is responsible for the person-centered service plan development;

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Prior to service plan development, the individual identifies the people in his/her life that he/she would like to have support him/her with planning. Case managers and other team members are strongly encouraged to explore and develop "planning partners" (someone to help the individual set service plan meeting times and locations, as well as help the individual understand and direct his/her own service planning) and circles of support for individuals. This might include, for some individuals, the establishment of a microboard. The individual may wish to choose a planning partner who is a family member, a friend or a provider representative. A planning partner may be chosen from among all available team members. If the individual is not interested in a planning partner or is unable to find one, these activities remain the responsibility of the case manager.
The individual's preferences for the annual meeting are recorded in the personal profile including the support needed to direct and fully participate, the identified planning partner, meeting logistics, whom to invite, as well as any cultural and other considerations. The personal profile (a component of the Individual Support Plan) assists the individual and the people who support him/her to consider what is working and what is not working in all areas of living to better understand what is important to and important for the person. Other partners/providers participating in the planning share what they have learned about supporting the individual. Planning meetings focus on the individual's talents and gifts, desired outcomes and the role of each team member in undertaking the steps to achieve these outcomes.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The plan is developed by the individual and his/her chosen team members. At a minimum the case manager and the individual (legal guardian, as applicable) participate in service plan development, but typically all service providers are a part of the person-centered planning process. Other typically involved parties are members of the individual's family and other people who are significant to the individual. There shall be no more than 365 days between Individual Support Plan effective dates. The planning process may begin as early as eight weeks prior to the planned start date of the plan. The person-centered planning meeting should be scheduled at a time and location convenient to the individual. Information regarding Virginia's Person-Centered ISP and process can be found in the DBHDS Waiver Management System, by contacting the Division of Developmental Services, or by visiting http://www.dbhds.virginia.gov/developmental-services/provider-development.

(b) The CSB responsible for assessing an individual's needs gathers the "Essential Information" in concert with the individual and those who know him or her best. This includes elements such as contact information, health information, historical information regarding the individual's development, family, education, employment. Some other information gathered through this process is legal status and identified health and behavioral support needs as determined through the risk assessment. The Essential Information also includes the description of a plan for self-sufficiency and a review of most integrated settings with the actions that will be taken when something more integrated is desired.

The risk assessment is a component of the annual person-centered plan. The risk assessment, as a component of the essential information, must be completed every year. To assess other support needs, each individual 22 years of age and older has the Supports Intensity Scale® (SIS®) completed every four years or when the individual's needs change significantly. Youth 16 years of age through 21 years of age have the Supports Intensity Scale® (SIS-A®) completed on at least a triennial basis or when the individual's needs change significantly. Those individuals 5 to 15 years old have the Children's SIS® or other approved alternative, developmentally appropriate assessment completed to assess their support needs on a biennial basis. Children under 5 years of age have their needs assessed biennially using an approved alternative, developmentally appropriate instrument.

Finally, the individual, with the support of anyone he or she chooses, completes the "personal profile." The personal profile considers eight life areas and compares the life the person has today with the life he wants. It is a snapshot of the individual's desires and is completed in preparation for annual planning. There are five parts to the personal profile: My Meeting, My Talents and Contributions, The Life I Want, My Life Today, and Getting the Life I Want (which identifies what's important to and what's important for the person in many different aspects of life).

The section "My Meeting" details individual preferences and needed supports for annual planning. "My Talents and Contributions" highlight great things about the person identifying abilities that can be developed and ways to connect the person with others. "My Life Today" briefly describes what the individual's life is like currently, which is contrasted with "The Life I Want" providing an opportunity for the individual to describe what a good life means to him/her. This description should capture the individual's vision of a desirable future and is completed following the identification of talents and contributions and the life area review.

The final section, "Getting the Life I Want," considers "what's working" and "what's not working" to arrive at what is important to and important for the person in regards to: home, community and interests, relationships, work and alternates to work, learning, money, transportation and travel and health and safety.

(c) The individual is informed of available waiver services by the case manager prior to enrollment. This is documented on the "Documentation of Individual Choice between Institutional Care or Home and Community-Based Services" form. Once the individual is enrolled in the waiver, the waiver services are once again presented, discussed, and choice of providers offered.

(d) The individual (or someone of his/her choosing) reviews the personal profile at the meeting. Partners share additional information which is added to the final version of the profile and agreed to by the individual. During the "shared planning" phase, the desired outcomes of the individual (including changes to the existing plan) for the next year are identified by determining what needs to remain the same, what needs to change and the balance between what is important to the individual and what is important for the individual's health, safety, and value in the community. The health portion of the "Essential Information" section of the person-centered plan, which is discussed during the shared planning phase, thoroughly queries the individual's past and present conditions/needs for support. To ensure that health and safety is addressed, each identified health and behavioral support need must be addressed

under outcomes developed during the shared planning process. Descriptions of the steps needed to resolve each outcome, data collection methods and target dates are included. The results of the SIS® (or other approved assessment for children), routine supports, and health and safety supports needed are discussed and providers are selected to assist with supporting the individual to accomplish the desired outcomes. An evaluation of how the plan achieves the desired outcomes, from the individual's and responsible partners' perspectives, is completed prior to final agreements.

(e) Waiver and nonwaiver services are coordinated by the case manager, who has responsibility for linking the individual to needed services and monitoring their receipt, regardless of funding source. As with all participating providers, the case manager outlines his/her supports to the individual in a "Plan for Supports" (a component of the overall ISP).

(f) All supports agreed to during the meeting are further defined by each provider following the meeting in their Plan for Supports. Support instructions, for each activity aimed at achieving desired outcomes and keeping the individual healthy and safe are developed specific to the individual's preferences. Descriptions of what is needed to consider each activity accomplished and the frequency of delivery are included. These Plans for Supports outline what the provider will do to support each outcome, how often/by when and how long, and include a schedule of services. Providers must document in the Plan for Supports any services that the individual has agreed to be delivered through telehealth as well as documentation that the individual has the ability to receive and benefit from this method of service delivery. The provider shall also document that any platform used to conduct telehealth activities are in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Before a telehealth option is requested and/or authorized for an individual, the individual's support team (Support Coordinator and requesting provider) should assess and document the individual's ability to be supported effectively via telehealth. This information should be documented clearly in the individual's plan for support. As appropriate, the support team should evaluate the individual's overall progress on identified goals and determine if telehealth delivery is having an impact on progression.

Providers should have information available for the individual and/or unpaid caregiver on how to access and utilize their HIPAA compliant telehealth platform. Specific adaptive needs may be assessed and potentially addressed using the Assistive Technology benefit of the waiver, provided all appropriate criteria apply. Waiver shall not be authorized for the provision of internet services. The state shall monitor compliance with these expectations via the approved quality management review process (QMR).

Providers of residential support, agency-directed personal assistance, group day, community engagement, community coaching, and supported employment services have the option of initially developing a "60-day assessment plan," an interim plan for the first 60 days that the individual is with a new provider or service. This is designed to permit the provider to gather some situational information about the individual, as well as to give the individual the opportunity to experience the provider/service. Towards the end of the 60-day period, a decision is made by both provider and individual to maintain or terminate the relationship. If the individual will be remaining with the provider, an "annual plan" addressing identified needs and preferences is developed and implemented.

The implementation of the Plans for Support are monitored by the case manager who receives quarterly reviews from each provider regarding the status of each outcome, changes to the support needs and preferences as more is learned about the individual, and changes needed to the plan as desired by the individual. The case manager also meets with the individual (and family/caregiver, as appropriate) at least every 90 days to discuss the status of supports received and resulting satisfaction/dissatisfaction.

(g) Whenever an individual requests a change, in services and/or providers, the individual and each provider work together to update the Plan for Supports, which is then sent to the case manager for approval. In addition, the Plan for Supports is reviewed at least quarterly by all providers, [per 12 VAC 35-105-660 (licensing regulations)], who must forward the results of their reviews to the case manager. The individual's or legal guardian's signature must be obtained for all changes to the plan.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the**

individual's needs, preferences, and, for residential settings, resources available for room and board.

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☑ **A specific and individualized assessed need for the modification.**
- ☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☑ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☑ **Informed consent of the individual.**
- ☑ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Currently, each provider licensed by DBHDS is required to identify a staff person responsible for risk management, document and implement a plan to identify, monitor, reduce, and minimize risks associated with personal injury, property damage or loss, and other source of potential liability. As part of the plan, the provider shall conduct and document at least annually its own safety inspections of all locations and document/implement needed safety improvements. The provider must implement written policies to identify individuals at risk for falls and develop and implement a fall prevention/management plan for each at risk individual. include policies to identify individuals at risk for falls and develop a prevention/management program. Providers must document serious injuries to employees and individuals and evaluate injuries at least annually, documenting and implementing recommendations for improvement. Providers must also develop, document and implement infection control measures, including the use of universal precautions to minimize the risk of infection/contagion. Finally, licensed providers are required to develop a written emergency preparedness and response plan for all services and locations [12 VAC 35-105-520]. DBHDS Office of Licensing staff make annual unannounced and announced onsite and desk reviews to ensure provider compliance with these regulations, as well evaluate the physical facilities in which the services are provided [12 VAC 35-105-70].

Annually, the case manager completes a risk assessment to determine individuals' potential risks, particularly health and behavioral. This information is used to inform the team's discussion at the individual's person-centered planning meeting, and supports required to minimize heath, physical, and social risks to the individual are included in the Individual Support Plan. The person-centered service plan has a section titled "shared planning" specifically to document health and safety related outcomes as identified in the risk assessment. Areas of potential risk to the individual that are identified on the annual risk assessment must be addressed under outcomes developed during the shared planning process. Activities related to this information are discussed at the annual planning meeting and detailed in each provider's Plan for Supports as necessary.

Individuals' person-centered service plans must include "Essential Information" in the form of emergency contact information, health information such as the presence of an advance directive, medication information (including location of side information), the presence of allergies, communicable diseases, mental health service needs, physical limitations and restrictions, chronic conditions, etc.

The individual is supported in selecting a variety of back-up measures including, but not limited to, natural/informal supports in the community or other agency-directed resources. Those providing back-up may be a family member, neighbor or friend willing and available to assist the individual in his or her home, if the scheduled service provider is unavailable. The case manager serves as a resource in assisting the individual and family in initial planning for needed supports in anticipation of program closures (e.g., for inclement weather). This activity is documented on the Individual Support Plan in the "Back-Up Plan" section of the essential information. For consumer-directed services, the importance of a back-up plan, types of back-up and the ways to develop a plan are also described in the Employee Management Manual, given to individuals upon becoming employers and reviewed by the services facilitator (until 5/31/27) and/or support broker (starting 3/1/27). Individuals who do not have back-up supports for Shared Living, Personal Assistance, Companion, or In-Home Support services in particular risk the denial of those services.

Community resources are identified and utilized to assist in the unlikely event that the individual has no family or friends to provide back-up supports. Options are individually identified based on individual needs and preferences. All available resources are considered during the planning process.

Individuals unable to identify adequate safeguards for back-up supports are not approved for waiver services. At this point, recommendations are made to the individual and family for identifying strategies to resolve the unmet back-up needs for future approval of waiver services. Referrals to other providers/services are also considered.

Plans for Supports (provider-specific service plans) are modified as individual needs change in order to ensure safety and continuing back-up for all services. As each individual's needs are unique, each Plan for Supports is reflective of specific supports required by that individual.

DMAS QMR verifies during their onsite reviews that individuals' service plans address all assessed needs, including risk factors and include necessary back-up plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The state ensures that each individual found eligible for the waiver will be given a choice of all qualified providers of each service included in his or her written service plan.

Individuals receive a list of service providers from the case manager at the time of enrollment into the waiver. In addition to providers listed on the DBHDS Licensing website, individuals have ongoing access to information about available providers through the case manager, should they be unsatisfied or for any other reason desire a change. Case managers are required to inquire about and document individuals' satisfaction with services on a quarterly basis.

The case manager provides support to the individual in the selection of service providers by encouraging the individual or family member/caregiver to directly contact the provider(s) to ask questions and gain information about the providers' service delivery philosophies and approaches. In some situations the case manager facilitates site visits. The case manager can assist the individual in identifying a provider to best meet his/her needs by discussing location, service delivery approach and other criteria important to the individual or family/caregiver.

For general documentation on freedom of choice of providers, the individual and/or his substitute decision maker reviews and signs the Virginia Informed Choice (VIC) at least annually. The VIC documents the provider options presented to the individual and what providers were selected. Additionally, the individual and/or his substitute decision maker reviews and signs (at least annually) the HCBS disclosure form, which also confirms the individual was provided a choice of providers.

This documentation is completed by the CSB Support Coordinator and is reviewed as part of the state's Quality Management Review (QMR) process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

As described in D-1d, the case manager submits service plan information to the operating agency, DBHDS, for service authorization. DBHDS employs Qualified Developmental Disability Professionals (QDDPs) to complete the approval/service authorization process. DMAS reviews a sample of DBHDS's service authorizations as part of its monitoring process.

In addition, all service plans are subject to review by the Medicaid agency via the Quality Management Review (QMR) to ensure that services are approved and appropriate for the individual. An approved sampling process is employed to determine the number of records reviewed for each provider. The purpose of the QMR is to determine whether services delivered were appropriate, continue to be needed by the individual, and the amount and kind of services delivered were required. DMAS analysts conduct QMR of all documentation, which shows the individual's level of care. Visits are conducted on-site and are unannounced. Quality Management Reviews are conducted continuously throughout the year.

The QMR visit is accomplished through a review of the individual's record, evaluation of the individual's health and functional status, and consultation with the individual and family/caregiver, as appropriate. Specific attention is paid to all applicable documentation, which may include assessments, service plans, consumer-directed services facilitator notes, daily logs, individual service authorization requests (through the waiver management system), schedules, attendance sheets, progress notes, and any other documentation necessary to determine if appropriate payment was made for services delivered. QMR reviews are conducted continuously.

A financial review is included as a part of a utilization review. The purpose of the financial review and verification of services is to ensure that the provider bills only for those services which have been provided in accordance with DMAS policy, are approved in the ISP, and are covered by the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- [ ] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case manager is responsible for monitoring the implementation of the ISP. The case manager must continuously monitor the appropriateness of the plan and make revisions as needed. At a minimum, the case manager must review each provider's quarterly review every three months to determine if the individual's outcomes and support activities are being met, determine if any modifications are necessary, confirm the status of the individual's health and welfare, and assess the individual's satisfaction with services.

The case manager is required to have a face-to-face contact with the individual at least every 90 days. The purpose of the face-to-face contact is to observe the individual, to verify services are being provided as described in the service plan, assess the individual's satisfaction with his choice of services/providers, ensure his/her health, safety and welfare, including the effectiveness of his back-up plans and identify any unmet needs or changes needed to the service plan. Back-up plan effectiveness is assessed by ensuring that the designated back-up person(s) were available and provided needed supports when the service provider was unavailable. If it is determined that this is not the case, an alternate back-up plan must be put into place or this individual must choose a service which offers continuous staff availability for continued enrollment in the waiver.

One of the case manager's duties is to link the individual to supports and services he needs, whether those services are waiver-funded or not. Examples of common nonwaiver-funded services are health services, therapies, camps and other vacation opportunities, and post-secondary education opportunities. Once the case manager has linked an individual to these supports, they should be included in the case management plan and monitored with a frequency appropriate to their provision.

If there is evidence of serious problems revealed upon case management review including 1) the individual, family, or primary caregiver is dissatisfied with services, 2) services are not delivered as described in the service plan, 3)failure of the provider/individual/family/AR to allow required monitoring visits, or 4) the individual's health and safety are at risk, the case manager must take necessary actions and document in the individual's appropriate record(s). Actions may include: requesting a written response from the provider; reporting the information to the appropriate licensing, certifying, or approving agency; reporting the information to DBHDS or DMAS; requiring that the provider participate in mandatory technical assistance and/or training in the violation area;informing the individual of other providers of the service in question; and as a last resort, after all other options to mitigate identified issues have been exhausted, informing the individual that eligibility may be in jeopardy should he or she choose to continue receiving services from a provider who cannot ensure health and safety or other requirements. Any time abuse, neglect, or exploitation is suspected, the case manager is required to inform Adult Protective Services or Child Protective Services, as appropriate (and DBHDS Office of Human Rights if it involves a DBHDS-licensed provider).

Information about monitoring results is conveyed to DBHDS quarterly via an on-line submission of case management supervisory review data. Data submitted (for a sample of each CSB's individuals receiving waiver services) include items for assessment of (1) whether all needs in the following areas were addressed by planned outcomes in the Individual Support Plan: work and alternatives to work, learning and other pursuits, community & interests, relationships, home, transportation & travel, money, health & safety;(2) whether the Individual Support Plan was updated/revised when the individual's needs changed, and (3) whether waiver services were delivered as delineated in the Individual Support Plan. If there are negative responses to any of these items, the reason and action taken to remediate the situation must be detailed in the information submitted to DBHDS.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ● **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

Private case management providers contracting with the local CSB may not provide any other waiver services to the individual other than Services Facilitation (until 5/31/27). CSBs may be providers of waiver services provided there is a separation of direct service provision units and case management units. It is never permitted for a case manager (employed by a CSB or private provider) to be a direct support provider or supervise direct support providers of waiver services for individuals for whom he/she provides case management.

Individuals who are dissatisfied with their case manager may choose another from the same agency, or (1) for ID case management, select another CSB that has a memorandum of agreement with the home CSB, (2) for DD case management, select either another CSB that has a memorandum of agreement with the home CSB or a private case management provider with which the CSB has a contract.

Case managers' monitoring of service provision and ensuring that the choices of the individual are implemented are reviewed by DBHDS and DMAS QMR staff.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP2. Number and percent of waiver individual records that indicate that a risk assessment was completed as required. N: Number of waiver individual records that indicate that a risk assessment was completed as required. D: Total number of waiver individual records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP3. # & % of individuals whose service plan includes a risk mitigation strat when the risk assessment indicates a need, including health & safety risk factors N: # of ind whose SP includes a risk mitigation strat when the risk assmnt indicates a need, including health & safety risk factors D: Total # of ind whose risk assmnt indicates a need for a risk mitigation strat that were reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check*	**Frequency of data collection/generation***(check*	**Sampling Approach** *(check each that*

each that applies):	*each that applies):*	*applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP1. Number and percent of individuals who have service plans that address their assessed needs, capabilities, desired outcomes, and goals. N: Number of individuals who have service plans that address their assessed needs, capabilities, desired outcomes, and goals D: Total number of individuals' records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP4. # & % of service plans that have a required back-up plan for services including in-home supports, personal assistance, respite, companion, & shared living N= # of service plans that have a required back-up plan for services including in-home supports, personal assistance, respite, companion, & shared living D= Total # of service plans that have a required back-up plan that were reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP6. Number and percent of individuals whose service plan was revised, as needed, to address changing needs. N: Number of individuals whose service plan was revised, as needed, to address changing needs D: Total number of individual service plans that needed to be revised due to changing needs that were reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach**

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% and +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP5. Number and percent of service plans reviewed and revised by the case manager by the individual's annual review date. N: Number of service plans reviewed and revised by the case manager by the individual's annual review date D: Total number of service plans reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP8. Number and percent of individuals who received services in the duration specified in the service plan. N: Number of individuals who received services in the duration specified in the service plan. D: Total number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100%**

		Review
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP9. Number and percent of individuals who received services of the type specified in the service plan. N: Number of individuals who received services of the type specified in the service plan. D: Number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP10. Number and percent of individuals who received services in the scope specified in the service plan. N: Number of individuals who received services in the scope specified in the service plan. D: number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP7. Number and percent of individuals who received services in the frequency specified in the service plan. N = Number of individuals who received services in the frequency specified in the individual service plan. D = Total number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP11. Number and percent of individuals who received services in the amount specified in the service plan. N: Number of individuals who received services in the amount specified in the service plan. D: Number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP12. # and % of individuals whose case management records contain an appropriately completed & signed form that specifies choice was offered among waiver services N: # of individuals whose case management records contain an appropriately completed & signed form that specifies choice was offered among waiver services D: Total number of individual's case management records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP13. Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual. N: Number of individual whose case management records documented that choice of waiver providers was provided to and discussed with the individual. D: Total number of individual's case management records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

As DMAS Quality Management Review (QMR) staff identifies problems with any of the above measures for a given provider, they require a Corrective Action Plan to be developed and implemented by that provider. Failure to do so jeopardizes the provider's Medicaid provider agreement. Serious violations may be referred to DMAS's Provider Integrity unit for payment retraction.

Individual providers with systemic problems will be targeted for technical assistance/training from DBHDS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Individuals are afforded the opportunity to act as the employer in the consumer-direction of personal assistance, respite, and companion services. This takes place in conjunction with their initial decision to receive waiver vs. institutional services and is documented on the same form (the "Documentation of Individual Choice Between Institutional Care or Home and Community-based Services" form). There may be other junctures at which this choice is also offered, e.g., once the individual is assigned a waiver slot or when the individual or family/caregiver expresses dissatisfaction with agency-directed services. The case manager, explaining the consumer-directed option should inform the individual and family/caregiver that this involves the hiring, training, supervision, and termination, if necessary, of consumer-directed assistants.

Individuals selecting services through the consumer-directed model may choose a Medicaid-enrolled services facilitator (SF) (until 5/31/27) and/or be referred by the support coordinator to support brokers (starting 3/1/27) to provide the training and guidance needed to be an employer. As the employer, the individual is eligible for and receives waiver services and is responsible for hiring, training, supervising, and firing assistants. The individual will be given an Employer Identification Number (EIN) for tax and payroll purposes through the Fiscal-Employer Agent contractor. If the individual is unable to independently manage his/her own consumer-directed services, or if the individual is under 18 years of age, a family member/caregiver, parent of the minor, or other designated adult must serve as the employer of record (EOR) on behalf of the individual for the purposes of hiring, supervising, training, approving work shifts, and, if necessary, dismissing the attendant. If the individual cannot receive an EIN due to (1) has not yet reached the age of majority; (2) is ineligible to use their existing EIN to facilitate the taxation of benefits; or (3) is otherwise determined ineligible by the State, an EIN shall be transferred or assigned to another person as EOR for taxation purposes. A services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) or person serving as an EOR cannot also be a paid caregiver. The SF (until 5/31/27) and/or support broker (starting 3/1/27) cannot also be the consumer-directed services employee.

SF (until 5/37/27) and/or support broker (starting 3/1/27) services must be authorized by DBHDS. The SF (until 5/31/27) and/or support broker (starting 3/1/27) completes an assessment for consumer-directed services, a Plan for Supports, and maintains documentation of services provided as outlined, including documentation of face-to-face visits with the individual at least every six months to ensure appropriateness of consumer-directed services.

Specific duties of the individual (or individual's employer of record) as the employer of the CD employee include: checking references, determining that the employee meets basic qualifications, training, supervising performance, and submitting work shifts to the Fiscal Management Services (FMS) agent on a consistent and timely basis.

When the case manager is also acting in the role as services facilitator (until 5/31/27) for a single individual, the face to face contact that she has as a case manager must be separate and distinct from the face to face visit she has in the role of services facilitator (until 5/31/27). There must be separate documentation for the two services as they are reimbursed separately.

All consumer-directed services require the services of a FMS agent. This is not a waiver service. As specified in the DMAS contract, the FMS agent conducts all payroll functions on behalf of the individual, including the requesting and processing of criminal background investigations, payment of assistants, and filing of IRS wage withholdings.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***.

Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☑ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Consumer-direction opportunities in the form of CD Companion services are available to individuals who reside in group homes of four or more persons unrelated to the proprietor.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Individuals assessed as having an intellectual disability that may limit or prevent the ability to consumer-direct services may designate a representative to act as the Employer of Record for consumer-directed supports on his or her behalf, or obtain agency-directed services. Individuals under the age of 18 must use a second person for day-to-day responsibilities. In these situations, for tax reporting purposes, the individual will be considered an EOR and receive an Employer Identification Number.

An individual shall not receive consumer-directed services if at least one of the following conditions exists:

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

In the above situation, the individual will be assisted by the case manager to select an agency from which to receive his personal assistance, respite, or companion services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the

benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager provides an informational overview of consumer-directed services to individuals and family members/caregivers, as appropriate, at the time the Individual Choice form is signed (prior to enrollment) and in more detail at the initial person-centered Individual Support Plan development meeting. Individuals electing to consumer-direct one or more services then select a services facilitator (SF) (until 5/31/27) and/or are referred to the support broker (starting 3/1/27). The SF (until 5/31/27) and/or support broker (starting 3/1/27) is responsible for initiating services with the individual upon being notified by the case manager of being chosen. The SF meets with the individual to determine his/her preferences and needs that will inform the development of the consumer-directed portion of the service plan.

The SF (until 5/31/27) and/or support broker (starting 3/1/27) provides the individual with a copy of the Employer Management Manual which details the responsibilities and liabilities of consumer-directing services, allowing the individual time to evaluate the pros and cons of consumer-direction and to make a final decision. The SF (until 5/31/27) and/or support broker (starting 3/1/27), using the DMAS Employer Management Manual, must provide training to the individual on the responsibilities of and procedures associated with consumer-direction within seven days of being authorized for consumer-directed services.

The support broker (starting 3/1/27) meets with the individual-or as indicated in E-1-d, the person the individual designates to perform day-to-day employer responsibilities-and determines if the individual is appropriate to perform the day-to-day responsibilities through a questionnaire. If the individual wishes to perform these duties , the support broker evaluates the individual's ability to manage their own services through the DMAS-95 Addendum, Questionnaire to Assess An Applicant's Ability to Independently Manage Consumer-Directed Services. If the individual has designated another person to perform the day-to-day duties, the support broker evaluates that person's ability to manage services through the DMAS-95B, Consumer-Direction Services Management Questionnaire.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ● **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Individuals who choose the consumer-directed model must have the capability to function as the employer and hire and train their own assistants and supervise their performance. If an individual is unable to direct his/her own supports or is under 18 years of age, a family member/caregiver may serve as the Employer of Record on behalf of the individual. For individuals appointing another person to direct supports on their behalf, the case manager ensures and documents that both parties have considered the responsibilities of this role and assesses that the selected person can perform these functions and will act in the best interest of the individual.

At the initial visit, if the individual has selected another person to perform the day-to-day EOR responsibilities, the support broker (starting 3/1/27) evaluates that person's ability to manage services through the DMAS-95B, Consumer-Direction Services Management Questionnaire. It is the responsibility of the SF (until 5/31/27) and/or support broker (starting 3/1/27) to provide ongoing support to the individual and employer of record (if applicable) in the consumer-directed model of support. As a safeguard, the SF (until 5/31/27) and/or support broker (starting 3/1/27) cannot be the individual, direct service provider, spouse or parent of the individual who is a minor child, the Employer of Record (EOR), or the attendant. The SF (until 5/31/27) and/or support broker (starting 3/1/27) monitors the service plan quarterly and on an as-needed basis and conducts a face-to-face meeting with the individual at least every six months to reassess the individual's needs and to ensure appropriateness of consumer-directed services received by the individual. During visits with the individual, the SF (until 5/31/27) and/or support broker (starting 3/1/27) must observe, evaluate and consult with the individual and his/her family member/caregiver, as appropriate, and document the adequacy and appropriateness of consumer-directed services for the individual's current functioning and cognitive status, medical needs and social needs. In addition, the SF (until 5/31/27) and/or support broker (starting 3/1/27) shall review timesheets during the visits or more often as needed, to ensure that the number of service plan approved hours is not exceeded. If discrepancies are identified, the SF (until 5/31/27) and/or support broker (starting 3/1/27) must discuss these with the individual or employer of record to resolve discrepancies and must notify the case manager and fiscal management services agent of the final decision.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Assistance Services	☑	☐
Respite	☑	☐
Companion Services	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

● **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

● **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Department of Medical Assistance Services secured financial management services for the consumer-directed model of service delivery through a competitive Request for Proposal process. DMAS holds a contract with a single fiscal employer agent (FEA).

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment is rendered to the FEA on a monthly billing cycle with a per member per month fee and includes all administrative functions specified in the contract between DMAS and the FEA. The percentage of FMS costs relative to the service costs is 2.4%.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**

☑ **Collect and process timesheets of support workers**

☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☑ **Other**

Specify:

The Fiscal Employer Agent is responsible for requesting criminal background screenings of potential consumer-directed employees. Additionally, the FEA requests screenings from the Department of Social Services Child Protective Services Central Registry, if the individual is a minor child. The FEA calculates eligibility for paid sick leave for consumer-directed attendants and maintains balances of accrual and usage of the paid sick leave benefit.

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**

☐ **Track and report participant funds, disbursements and the balance of participant funds**

☐ **Process and pay invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Department of Medical Assistance Services employs contract monitors to oversee and assess the performance and deliverables of the Fiscal Employer Agent. Payroll system edits are required as a part of the FEA contract and the contract monitors randomly conducts system checks for financial integrity. The contractor's performance is also assessed and evaluated in a bi-annual performance review and documented on a contract monitoring evaluation form.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The individual's case manager informs him/her (and family members/caregivers, as appropriate) about the option of consumer-directed personal assistance, respite, and companion services at the point of enrollment and at other appropriate junctures, such as at the annual Individual Support Plan meeting or when a request for alternative services is made. When consumer-directed personal assistance, respite, or companion services are chosen, the case manager facilitates the individual's access to consumer-directed services by offering the choice of services facilitators (until 5/31/27) and/or makes a referral to the support broker (starting 3/1/27) and linking the individual to the Medicaid enrolled SF of his/her choice (until 5/31/27) and/or the support broker (starting 3/1/27).

The case manager submits information regarding consumer-directed services to DBHDS for service authorization and, following that event, monitors the consumer-directed service via quarterly reviews submitted by the SF (until 5/31/27) and/or support broker (starting 3/1/27) and face-to-face contacts with the individual enrolled in the waiver.

☑ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Group Supported Employment	☐
Community Engagement	☐
Crisis Support Services	☐
Center-based Crisis Supports	☐
Personal Emergency Response System	☐
Shared Living	☐
Personal Assistance Services	☐
Employment and community transportation	☐
Benefits Planning	☐
Supported Living	☐
Assistive Technology	☐
Respite	☐
Electronic Home-Based Services	☐
Companion Services	☐
Transition Services	☐
Group Home Residential	☐
Consumer-Directed Services Facilitation (until 5/31/27)	☑
Therapeutic Consultation	☐
Group Day Services	☐
Community Guide	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Community-Based Crisis Supports	☐
Sponsored Residential	☐
In-home Support Services	☐
Environmental Modifications	☐
Skilled Nursing	☐
Workplace Assistance Services	☐
Community Coaching	☐
Private Duty Nursing	☐
Peer Mentor Supports	☐
Individual Supported Employment	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The State enters into a contract with its fiscal-employer agent (F/EA) to provide support broker information and assistance services to all persons receiving CD services. This contract is slated to go into effect on January 1, 2027 with the rollout of support broker supports starting with individuals who use CD services on March 1, 2027. Support brokers hired through the F/EA are distinct from those who perform payroll and tax functions within the F/EA.

Support broker services are procured through the F/EA contract that the State has with the existing F/EA. The Department of Medical Assistance Services secured financial management services for the consumer-directed model of service delivery through a competitive Request for Proposal process. DMAS holds a contract with a single fiscal employer agent (FEA). Payment is rendered to the FEA on a monthly billing cycle with a per member per month fee and includes all administrative functions specified in the contract between DMAS and the F/EA. The percentage of support broker costs through the F/EA relative to the service costs is 2.4%.

Support brokers perform the function to assist the individual (or the individual's family or representative, as appropriate) in arranging for, directing, and managing their own consumer-directed waiver services. Serving as the agent of the individual or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs within the consumer-directed suite of services, and training the individual/family to be the employer. Practical skills training is offered to enable families and individuals to independently direct and manage their waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that individuals understand the responsibilities involved with directing their services. The extent of the assistance furnished to the individual or family is specified in the service plan. Support brokers duplicates services facilitation. An individual may not receive Services Facilitation and support via a support broker.

Support brokers are responsible for conducting quarterly visits with the individual to ensure that consumer-directed services are meeting the individual's needs. These quarterly visits include an assessment of the individual and any needed adjustments to the Plan of Care based on the individual's assessed needs with the individual's involvement. The support broker is responsible for submitting service authorization requests for consumer-directed services. Between visits, support brokers are available via phone and email to assist the EOR with questions or issues when it comes to managing services, respond to the individual in case the individual experiences a change and would like a reassessment, and other concerns with the provision of consumer-directed services.

The Department of Medical Assistance Services is responsible for assessing performance of the support broker contract and employs contract monitors to oversee and assess the performance and deliverables of the support broker component of Fiscal Employer Agent's contract. Contract deliverables include reviews that hired support brokers meet the minimum qualifications; that support brokers conduct visits within the prescribed quarterly timelines; and that service authorizations are submitted timely to prevent gaps in authorized services, among others. The contractor's performance is also assessed and evaluated in a bi-annual performance review and documented on a Contract Monitoring Evaluation Form. The F/EA is also responsible for day-to-day oversight of their support brokers.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Individuals may elect at any time to initiate or discontinue consumer-directing their supports. The individual also may exercise the option of combining agency-directed and consumer-directed supports in order to meet his/her service needs. In the event that an individual elects to discontinue consumer-directed services but still needs and desires similar services, the case manager will aid the individual in selecting and securing services from an agency provider by offering choice of agency-directed providers and linking the individual with the Medicaid-enrolled provider of choice.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) or case manager, as appropriate, shall initiate involuntary disenrollment from consumer direction of the individual when any of the following conditions occur:

(1) The health, safety, or welfare of the individual 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, such as a history of frequent and repeated non-compliance with Electronic Visit Verification requirements.

Prior to involuntary disenrollment, the services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) 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 (until 5/31/27) and/or support broker (starting 3/1/27) 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 such involuntary termination of consumer direction. Such notice shall be given at least 10 business days prior to the effective date of this action.

If the services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) initiates the involuntary disenrollment from consumer direction, then he shall inform the case manager. The individual shall be permitted to select an agency from which to receive his personal assistance, respite, or companion services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	1300	
Year 2	1300	
Year 3	1300	
Year 4	1300	
Year 5	1300	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The contracted FMS requests and obtains criminal history checks of self-directed employees on behalf of the individual/employer. The FMS receives reimbursement for the cost of these investigations as a part of the administrative contract billing.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The method to conduct background checks does not vary from Appendix C-2-a

☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☑ **Schedule staff**

☑ **Orient and instruct staff in duties**

☑ **Supervise staff**

☑ **Evaluate staff performance**

☑ **Verify time worked by staff and approve time sheets**

☑ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

State regulations at Virginia Administrative Code § 12VAC 30-110-70 through 90 and federal regulations, Code of Federal Regulations 42 CFR Part 431, Subpart E require a "Notice of Appeal Rights" be sent to individuals who have an adverse action related to choice of home and community based services (HCBS) versus institutional services, choice of providers, and/or had a Medicaid-covered service denied, reduced, suspended, terminated or not acted upon within required time frames.

The individual must be notified in writing of the right to a hearing and the procedure for requesting a hearing at the time of the application and at the time of any adverse action by DMAS or its designee. For individuals not fluent in English, the information must be available to be translated into their native language or if they are not literate, an interpreter must be available to explain their right to an appeal in their native language. Notices must be issued at least 10 days prior to the date of action, except for those situations specified in law or regulations. The individual then has 30 days from the date of denial to request an appeal.

When an individual's request for a Medicaid-covered service is denied, reduced, suspended, terminated, or not acted upon within required time frames, the Case Manager/Support Coordinator must send the written notification of the action and the right to appeal the action to the individual.
The contents of the notification letter must include:

1. What action or adverse determination the agency intends to take and the effective date of such action;
2. A clear statement of the specific reasons supporting the intended action or adverse determination;
3. The specific regulations that support or the change in law that requires the action or adverse determination;
4. The right to request an evidentiary hearing, and the methods and time limits for doing so;
5. The right to request an expedited evidentiary hearing;
6. The circumstances under which benefits are continued if a hearing is requested; and
7. The right to representation.

Unless otherwise specified, written notification must be mailed by the Case Manager/Support Coordinator to the individual or legal guardian at least 10 days prior to the date of action when an agency reduces, suspends, or terminates one or all Medicaid-covered services.

Exceptions to the 10-Day Advance Notice Requirements:

The 10-day advance written notice is required to be sent to the individual or legal guardian except in the following instances: (Note that the written notice is required, even though advance notice is not.)

1. When the agency has factual information confirming the death of an individual;
2. When an individual or guardian provides a written request indicating that:
   a) He/she no longer wishes services to continue; OR
   b) He/she gives information that requires termination or reduction and indicates an understanding of the action required by supplying this information;
3. The individual has been admitted to an institution and is ineligible for further services, including a regular admission to an ICF/ID or a nursing home, or has been incarcerated;
4. The individual's whereabouts are unknown, as evidenced by returned mail;
5. The agency establishes the fact that the individual has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
6. The individual's physician prescribes a change in the level of care;
7. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act.
8. The date of action will occur in less than 10 days, in accordance with 42 CFR § 483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements.

All notification letters must be filed in the case management/support coordination record.

Appeals can be filed in writing or requested verbally. The deadline to file the appeal is within 30 days of receipt of the notice of adverse action. If completed in writing, the client or his authorized representative may use a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at local departments of social services, or by calling (804) 371-8488. DMAS also accepts appeals through its portal - the Appeals Information Management System. A copy of the notice or letter about the action should be included with the appeal request.

The DMAS address for mailing or delivering an appeal is:
Appeals Division

Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Appeal requests may also be faxed to: (804) 371-8491
The email address is appeals@dmas.virginia.gov
The portal is available at https://www.dmas.virginia.gov/appeals/

If an appeal is filed before the effective date of the action, services may continue during the appeal process.

In addition, at the time of any adverse action by DMAS, DBHDS, the CSB, or the Dept. of Social Services the individual must be issued a letter notifying him/her of his/her right to appeal that contains a statement to the effect of,

"If this is a termination or reduction in services and if you file an appeal before the effective date of this action, [date], services may continue during the appeal process. However, if you appeal and the Appeals Division upholds this decision, you may be required to reimburse the Medical Assistance Program for the waiver services provided after [date]. Additionally, if you file an appeal, you must inform your case manager/support coordinator of this action in order for your services to continue beyond the above stated end date.""

After receiving confirmation from DMAS that an appeal has been validated and that continued coverage applies, the case manager/support coordinator must notify the provider (after confirming with the individual or family member/caregiver, if applicable, that the individual wishes to receive continued services) that services must continue at the same level until the appeal decision is rendered.

Similarly, in the case of the discharge, if the individual files an appeal during the 30 days following notification of discharge, the appropriate entity must be notified and the waiver slot must remain assigned to the current individual until an appeal decision has been issued. If the individual does not appeal within 30 days following the date of notification, the slot may be reassigned.

If the agency's action is upheld by the hearing officer, and services were continued solely because of the appeal, the individual may be required to repay DMAS for all services received during the appeal period. For this reason, the individual may choose not to receive continued services.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ● **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

DMAS investigates all civil rights related grievances or complaints.

For non-civil rights matters, individuals receiving supports through the waiver may register a grievance or complaint with DMAS or DBHDS and are informed that filing a grievance or making a complaint are not a pre-requisite or substitute for a fair hearing.

• **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Information on how to file a civil rights grievance/complaint with DMAS is included on a non-discrimination statement that accompanies the notice of action. The DMAS website (www.dmas.virginia.gov) also includes a non-discrimination page, with the following information:
If you believe that this agency has failed to provide [language or disability access] services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

DMAS Civil Rights Coordinator
- In person or by mail:

600 E. Broad St.
Richmond, VA 23219
- By phone:

(804) 786-7933 (TTY: 1-800-343-0634)
You may also file a civil rights complaint with:
U.S. Department of Health and Human Services, Office for Civil Rights
- electronically: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by mail:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201;
- by phone:

1-800-368-1019 (TTY: 1-800-537-7697)
- Complaint forms are available at: https://hhs.gov/ocr/office/file/index.html

For non-civil rights issues, DMAS refers any complaints/grievances received to the operating agency, DBHDS. For these non-civil rights issues, the agency does not have a formal complaint system but does ensure that concerns expressed are taken seriously and efforts are made to investigate and resolve them. Concerns are directed to appropriate staff and documentation is kept of the efforts made and final resolution.

The individual is informed that they may file a grievance or make a complaint upon entrance into the waiver through correspondence from DMAS and through meetings with their Case Manager/Support Coordinator and Services Facilitator (until 5/31/27) and/or support broker (starting 3/1/27) when reviewing their service plan.

If a service provider has an internal appeal process, the individual need not utilize the provider's in-house appeal process as a prerequisite to filing for a fair hearing directly with DMAS. The individual can utilize the provider's appeal process or appeal directly to DMAS or participate in both processes simultaneously.

Individuals may request a fair hearing at any time. They need not file a complaint or grievance first.

The state also accepts complaints that include, but are not limited to, concerns with regulations, licensing, human rights, provider fraud, abuse/neglect/exploitation allegations, and general constituent concerns [both from self-advocates and families/legal decision makers]. A complaint may be filed via email, telephone, online data collection form, or via an online portal through the Office of Licensing or Office of Human Rights at DBHDS. If the concern or complaint is received via email or phone, the concern or complaint is entered into data system for review by the appropriate staff. If the allegation is more appropriate for an external enforcement agency it is encouraged for the constituent to additional file a complaint with that entity.

The state ensures that complaints are thoroughly addressed in a timely manner. When a complaint is filed, the following information is asked in order to contact the complainant during a possible investigation: Name, address, telephone number and details of the complaint to include date, time, location and name of involved employee(s) or other persons, if known. If the complainant wishes to remain anonymous, the complainant does not need to provide their name or contact information. However, if the complainant chooses to remain anonymous, this may prevent staff from contacting the complainant for additional information related to the complaint in needed.
Depending upon the nature and scope of the complaint, additional state agencies may be engaged for additional following up including: the Virginia Department of Social Services (VDSS); the Virginia Department of Health Professionals (DHP); the Virginia Department of Health (VDH); and/or local police/legal authorities.

If the complaint alleges a violation of the regulations, a formal investigation may be conducted. Methods of investigations may include conducting announced or unannounced on-site inspections and/or in-office reviews, that consist of a review of records, a review of provider reports or telephone interviews. An investigation may take up to 60 days to complete. Not all investigations will result in a finding or a citation. If there are findings, a report will be issued within 45 business days to include citations, remediation, etc. The provider then has 15 business days to respond to the report with a Corrective Action Plan (CAP). If the provider's response is accepted, then the response will be placed on the Office of Licensing website within the Licensed Provider Search System (LPSS). If the response is not accepted, the provider will be issued another 10 business days until there is an appropriate response to the CAP.

A complaint may also necessitate a referral to the Program Integrity unit within DMAS. A referral is staffed within 10 business days of receipt with the Program Integrity unit. Upon review, Program Integrity will determine if the complaint meets criteria for referral to the state's Medicaid Fraud Control Unit (MFCU).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

There are several elements to Virginia's Critical Incident Reporting and Management process.

I. FOR ALL PROVIDERS OF SERVICES IN THIS WAIVER
Overall state critical incident reporting requirements are under the purview of the Virginia Department of Aging and Rehabilitative Services (DARS) for adults and the Virginia Department of Social Services (VDSS) for children. Protective services for adults are described in the Virginia State Code at §63.2-1605. Protective services for children are described in the Virginia State Code at §63.2-1501 et. seq.

Adult Protective Services (APS) investigates reports of abuse, neglect, and exploitation of adults 60 years of age or older and incapacitated adults (inclusive of individuals with I/DD) age 18 or older. APS also assists in the development and implementation of programs to respond to and prevent adult abuse, neglect, or exploitation; prepares, disseminates, and presents educational programs and materials on adult abuse, neglect, and exploitation to mandated reporters and the public; and operates the APS 24-hour toll-free hotline (1-888-832-3858) and provides training and technical assistance to the hotline staff.

Reports of suspected abuse, neglect, or exploitation of adults must be made to the local department or the APS hotline.

Upon receipt of a report of suspected abuse, neglect, or exploitation of an adult, the local department determines the validity of the report and initiates an investigation within 24 hours of the time the report is received. APS must also refer any appropriate matter and all relevant documentation to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation.

In the case of children, the local department of social services (ldss) that first receives a complaint or report of child abuse, neglect or exploitation assumes responsibility to ensure that a family assessment or an investigation is conducted. All complaints and reports of suspected child abuse, neglect, or exploitation are recorded in the child abuse and neglect information system and either screened out or determined valid. In all valid complaints or reports of child abuse or neglect the ldss shall determine whether to conduct an investigation or a family assessment. A valid complaint or report is one in which: (i) the alleged victim child or children are under the age of 18 years at the time of the complaint or report; (ii) the alleged abuser is the alleged victim child's parent or other caretaker; (iii) the local department receiving the complaint or report has jurisdiction; and (iv) the circumstances described allege suspected child abuse or neglect as defined in § 63.2-100 of the Code of Virginia. This reporting is in addition to any required reporting by DBHDS when an incident has occurred for an individual receiving services from a licensed program.

To make a complaint or report of child abuse or neglect, a person may telephone the VDSS 24-hour toll-free child abuse and neglect hotline (1-800-552-7096), contact a local department of social services pursuant to §63.2-1510 of the Code of Virginia, or through the VaCPS Mandated Reporter Portal at https://vacps.dss.virginia.gov/VACPSWeb/faces/landingPage.xhtml.

Virginia defines these terms for adults as follows:

"Adult Abuse" means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult as defined in § 63.2-1603.

"Incapacitated Person" means any adult who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age or other causes to the extent that the adult lacks sufficient understanding or capacity to make, communicate or carry out responsible decisions concerning his or her well-being.

"Adult Neglect" means that an adult as defined in § 63.2-1603 is living under such circumstances that he is not able to provide for himself or is not being provided services necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being. However, no adult shall be considered neglected solely on the basis that such adult is receiving religious nonmedical treatment or religious nonmedical nursing care in lieu of medical care, provided that such treatment or care is performed in good faith and in accordance with the religious practices of the adult and there is a written or oral expression of consent by that adult.

"Adult exploitation" means the illegal, unauthorized, improper, or fraudulent use of an adult as defined in § 63.2-1603 or his funds, property, benefits, resources, or other assets for another's profit, benefit, or advantage, including a caregiver or person serving in a fiduciary capacity, or that deprives the adult of his rightful use of or access to such funds, property,

benefits, resources, or other assets. "Adult exploitation" includes (i) an intentional breach of a fiduciary obligation to an adult to his detriment or an intentional failure to use the financial resources of an adult in a manner that results in neglect of such adult; (ii) the acquisition, possession, or control of an adult's financial resources or property through the use of undue influence, coercion, or duress; and (iii) forcing or coercing an adult to pay for goods or services or perform services against his will for another's profit, benefit, or advantage if the adult did not agree, or was tricked, misled, or defrauded into agreeing, to pay for such goods or services or to perform such services. [§63.2-100].

Any person may voluntarily report suspected "abuse, neglect and exploitation" (in various forms) to the LDSS or the APS Hotline. The Code of Virginia (§ 63.2-1606) requires those designated as "mandated reporters" immediately, upon determining there is a reason for suspicion, report any suspected instances of abuse, neglect, or exploitation to the local department or the protective services hotline. Mandated reporters for APS include the following persons acting in their professional capacity:

1. Any person licensed, certified, or registered by health regulatory boards listed in §54.1-2503, with the exception of persons licensed by the Board of Veterinary Medicine;
2. Any mental health services provider as defined in §54.1-2400.1;
3. Any emergency medical services personnel certified by the Board of Health pursuant to §32.1-111.5, unless such provider immediately reports the suspected abuse, neglect or exploitation directly to the attending physician at the hospital to which the adult is transported, who shall make such report forthwith;
4. Any guardian or conservator of an adult;
5. Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive or direct care capacity;
6. Any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to, companion, chore, homemaker, and personal care workers; and
7. Any law-enforcement or probation officer.

Mandated reporters for CPS include the following persons acting in their professional or official capacity:
1. Any person licensed to practice medicine or any of the healing arts;
2. Any hospital resident or intern, and any person employed in the nursing profession;
3. Any person employed as a social worker or family-services specialist;
4. Any probation officer;
5. Any teacher or other person employed in a public or private school, kindergarten or nursery school;
6. Any person providing full-time or part-time child care for pay on a regularly planned basis;
7. Any mental health professional;
8. Any law-enforcement officer or animal control officer;
9. Any mediator eligible to receive court referrals pursuant to § 8.01-576.8;
10. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;
11. Any person 18 years of age or older associated with or employed by any public or private organization responsible for the care, custody or control of children;
12. Any person who is designated a court-appointed special advocate pursuant to Article 5 (§ 9.1-151 et seq.) of Chapter 1 of Title 9.1;
13. Any person 18 years of age or older who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect;
14. Any person employed by a local department as defined in § 63.2-100 who determines eligibility for public assistance;
15. Any emergency medical services provider certified by the Board of Health pursuant to § 32.1-111.5, unless such provider immediately reports the matter directly to the attending physician at the hospital to which the child is transported, who shall make such report forthwith;
16. Any athletic coach, director or other person 18 years of age or older employed by or volunteering with a private sports organization or team;
17. Administrators or employees 18 years of age or older of public or private day camps, youth centers and youth recreation programs; and
18. Any person employed by a public or private institution of higher education other than an attorney who is employed by a public or private institution of higher education as it relates to information gained in the course of providing legal representation to a client.

Local departments or the APS 24-hour, toll-free hotline, upon receiving the initial report, must immediately notify the

local law-enforcement agency when in receipt of a report describing any of the following:

1. Sexual abuse as defined in §18.2-67.10;
2. Death that is believed to be the result of abuse or neglect;
3. Serious bodily injury or disease as defined in § 18.2-369 that is believed to be the result of abuse or neglect;
4. Suspected financial exploitation of an adult; or
5. Any other criminal activity involving abuse or neglect that places the individual in imminent danger of death or serious bodily harm.

For CPS, the local department must notify the local attorney for the Commonwealth and the local law-enforcement agency immediately, but in no case more than two hours of receipt of the complaint, for all complaints of suspected child abuse or neglect involving the following:
1. Death of a child;
2. Injury or threatened injury to the child in which a felony or Class 1 misdemeanor is also suspected;
3. Sexual abuse, suspected sexual abuse or other sexual offense involving a child, including but not limited to the use or display of the child in sexually explicit visual material, as defined in § 18.2-374.1;
4. Abduction of a child;
5. Felony or Class 1 misdemeanor drug offense involving a child; and
6. Contributing to the delinquency of a minor in violation of § 18.2-371

Providers opting to render services via a telehealth model remain mandatory reporters for abuse, neglect and/or exploitation. They are required to intervene if any possibility of harm to the individual is suspected.

APS has 45 days to complete the investigation, APS investigations may be extended beyond 45 days if the worker documents the reasons for the delay (22VAC30-100-40). Notification of the completion of the investigation shall be made in writing and shall be mailed to the reporter within 10 working days of the completion of the investigation. (22VAC30-100-40).

CPS has 45 days to complete investigations but there are exceptions and circumstances that allow longer time. CPS timeframes are found in §§ 63.2-1505 and 63.2-1506 of the Code of Virginia.

II. FOR DBHDS-LICENSED PROVIDERS
Licensing and Human Rights regulations [12 VAC 35-105-160 and 12 VAC 35-115-230] state that the provider shall collect, maintain and report:

1. Each allegation of abuse, neglect, or exploitation to the assigned human rights advocate within 24 hours from the receipt of the initial allegation. These reports are currently made electronically through the Computerized Human Rights Information System (CHRIS). The provider shall provide a report through CHRIS of the results of the investigation of abuse, neglect, or exploitation to the provider and the human rights advocate within 10 working days from the date the investigation began. The report shall include but not be limited to the following: whether abuse, neglect or exploitation occurred; type of abuse; and whether the act resulted in physical or psychological injury.

2. Level II and III serious incidents (as defined in 12 VAC 35-105-20) via CHRIS to DBHDS within 24 hours of discovery, and by phone to the legally authorized representative as applicable within 24 hours. This report should include: the date, place, and circumstances of the serious incident; if a serious injury or death, the nature of injuries and treatment required and circumstances of such death or serious injury. For all other Level II and III serious incidents, the reported information shall also include the consequences that resulted.

Level I serious incidents are not required to be reported to the state's Office of Licensing via the CHRIS [state reporting] system. Licensing regulation 12VAC35-105-160, however, requires all non-children's residential providers to collect, maintain, and review all serious incidents, including Level I incidents, at least quarterly as part of the providers quality improvement plan. The quality improvement plan is subject to audit from the state's Office of Licensing.

3. Each instance of seclusion or restraint that does not comply with the human rights regulations or approved variances, or that results in injury to an individual within 24 hours to the legally authorized representative and, via CHRIS, to the assigned human rights advocate.

The Human Rights Advocate and the Local Human Rights Committee (LHRC) receive information from providers on the type, resolution level, and findings of each complaint of a human rights violation and implementation of variances in accordance with the LHRC meeting schedule or as requested by the advocate.

DMAS receives telephone reports of complaints (some involving critical incidents) related to Medicaid providers. These are referred to VDSS, local departments of social services (LDSS), DBHDS or other appropriate agency for follow-up, if appropriate. Also, these complaints may result in provider getting a DMAS Quality Management Review (QMR). During on-site visits, QMR staff report any identified health and safety violations to DBHDS, VDSS, LDSS or other appropriate agency as required by law. The QMR includes seeking information on incidents that should have been reported and the actual disposition.

New providers are trained by the Human Rights Advocate on what would be considered elements of a good investigation during the initial onsite provider review. This happens between 30-60 days of licensing. The Human Rights Advocate also provides ongoing regional training on human rights, to include investigations, for all existing providers. Information and training on investigations is available on the DBHDS website. A thorough investigation may include the following:
•Recognize the event (i.e., abuse, neglect) that requires an investigation;
•Take immediate action to ensure safety of individual(s);
•Complete and document required initial reporting (CHRIS, DSS, Law Enforcement as applicable);
•Collect relevant facts (medical records, case notes, incident reports, photographs, videos, etc.);
•Conduct interviews and collect written statements from everyone involved or knowledgeable of the incident;
•Analyze, inventory, and maintain evidence in accordance with procedures;
•Identify Corrective Action;
•Summarize and report findings along with corrective action plan to DBHDS and individual(s) involved;
•Implement and track any appropriate administrative or clinical care and treatment-related actions in order to prevent future occurrences, when it is determined that a violation has occurred; and
•Decide whether an administrative intervention is necessary (i.e., policy review, continued fact-finding), when it is determined that a violation has not occurred.

(a) Licensing Regulations require providers to report all Level II and Level III serious incidents using the department's web-based reporting application and by telephone to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery.
(b) For Children's regs: 12VAC35-46-1070. Serious incident reports. A. Any serious incident, accident, or injury to the resident; any overnight absence from the facility without permission; any runaway; and any other unexplained absence shall be reported within 24 hours (i) to the placing agency; (ii) to either the parent or legal guardian, or both as appropriate; and (iii) noted in the resident's record.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information and training regarding human rights protections required by DBHDS Office of Human Rights regulations (12 VAC 35-115-10-260) is provided to the individual and family/caregiver, as applicable, by the case manager and all DBHDS-licensed providers at the initiation of Waiver services and annually thereafter. These include the individuals' right to be free from abuse, neglect and exploitation. Individuals are also informed by their case manager that they may make a report directly to Adult/Child Protective Services, the local human rights committee or other direct care providers or professionals, to register a complaint on his or her behalf.

The case manager at the local Community Services Board provides education to individuals and their substitute decision makers on how to report incidents of abuse, neglect and exploitation to their local APS/CPS offices. It is incumbent upon the community services board to ensure that the case managers are aware of the proper resources and that those are shared with the individuals.

DMAS offers annual training to QMR staff on how to recognize and report abuse, neglect and exploitation.

DMAS continues to stress the importance of the protection from abuse, neglect, and exploitation of the Commonwealth's older adults and citizens with disabilities. The Guide for Long-Term Care Services in Virginia (rev. 5/21/2021), available on the Virginia Health Information (VHI) website and distributed to all local departments of social services, contains information on reporting abuse, neglect and exploitation. The Consumer-Directed Employer of Record Manual (rev. August 2021), utilized by consumer-directed employers and services facilitators (until 5/31/27) and/or support broker (starting 3/1/27), includes information about abuse, neglect and exploitation as well as the APS/CPS hotlines.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

I. APS receives and responds to all reports of critical incidents of abuse, neglect or exploitation, as required by their regulations. Reports are investigated by assigned APS staff members who must initiate an investigation of a valid report within 24 hours of report receipt. Investigations are finalized and closed as soon as possible given the nature and extent of the complaint. The complainant is informed of the investigation disposition (founded or unfounded) at case closure. APS has 45 days to complete the investigation--though regulations permit an extension if the APS worker documents the reason for the delay--and 10 days after the completion of the investigation to notify the complainant of the results.

CPS responds to valid reports of child abuse or neglect as required by their regulations 22VAC40-705 and 22VAC40-730 and guidance manual.

II. The DBHDS Office of Licensing receive reports of critical incidents (i.e., serious injuries or deaths) of individuals in DBHDS-licensed settings) via a self-report, provider staff, family members, advocates and other community members. Providers are required to make these reports within 24 hours of discovery via CHRIS. DBHDS staff conducts announced and unannounced onsite and desk reviews at any time and as part of the investigations of complaints or incidents as needed. Providers must report each allegation of abuse or neglect to the assigned human rights advocate within 24 hours from the receipt of the initial allegation. The provider submits a report via CHRIS of the results of the investigation of abuse or neglect to the Office of Human Rights within 10 working days from the date the investigation began unless an exemption has been granted. The report shall include but not be limited to the following: whether abuse, neglect or exploitation occurred; the type of abuse; and whether the act resulted in physical or psychological injury. Deaths and serious injuries must be reported to DBHDS within 24 hours of discovery via CHRIS. The report must include the date and place of death or serious injury, the nature of injuries and treatment required and the circumstances of death or serious injury.

The provider shall conduct a root cause analysis within 30 days of discovery of the serious incident that occurred during the provision of a service or on the provider's premises. The root cause analysis shall include at least the following information:
1. A detailed description of what happened;
2. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and
3. Identified solutions to mitigate its reoccurrence and future risk of harm when applicable.

If the DBHDS Office of Licensing detects noncompliance with any licensing regulations, including critical incident reporting, DBHDS develops a findings report requiring that the provider submit a corrective action plan to DBHDS within 15 business days of the issuance of the licensing report. Extensions may be granted when requested but are not to exceed an additional 10 business days.

III. DBHDS Office of Human Rights Advocates are required to close CHRIS cases within 60 days of initial notification. This is monitored by the Human Rights Regional Manager.

Office of Human Rights protocols require the responsible Advocate to verify that all provider corrective actions are being implemented. Cases are not closed until verification of implementation is documented by the Advocate in the advocate action section of CHRIS. In the event that the timeframe is extended due to a "pending higher level appeal" or when there is a delayed response from the provider, the assigned Advocate refers the case for further action to the Regional Manager.

The advocate may verify implementation of any corrective action through additional onsite visits and/or reviews of policies and/or other documents.

Proposed updates to waiver regulations will require providers with a history of noncompliance with regulations, as evidenced by multiple citations by either DBHDS Office of Licensing or DMAS QMR, resulting in the need for a corrective action plan in key identified areas such as health, safety, or failure to address the identified needs of the individual, will be required to undergo mandatory training and technical assistance in the specific area(s) of noncompliance. Failure to complete the mandatory training or identified technical assistance may result in referral to DMAS Provider Integrity or termination of the provider's Medicaid participation agreement.

Investigations:
Licensed providers are required to conduct internal investigations of serious incidents and allegations of abuse and neglect and report their findings to the Department. Newly licensed providers receive on-site and virtual training by the

Office of Human Rights regarding what is reportable as abuse, neglect and serious injury and how to submit the report in CHRIS. Providers also have access to training resources and tools related to conducting abuse/neglect investigations via the DBHDS website.

Licensing and Human Rights staff monitor provider reports and investigations through CHRIS. Licensing and Human Rights staff conduct independent investigations when reported incidents result in an individual's death or are otherwise determined to require additional oversight.

All Human Rights and Licensing staff attend competency-based training course resulting in certification to conduct serious incident investigations. The following are standard components that staff is taught during this training:

*Systematic process of evidence collection for the purpose of describing and explaining an incident.
*How to draw conclusions and utilize standardized tools for reporting investigative findings
*Effective ways of collecting relevant facts through interviewing witnesses, reviewing documentation and examining physical evidence.
*Utilization of agency protocols regarding when to include other agencies like Social Services, Law Enforcement etc. and instruction to defer to the Investigator Manual for ongoing consistency.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The DBHDS Office of Human Rights (OHR) has an electronic reporting system ("CHRIS") that relays information from all DBHDS-licensed providers to OHR regarding reported instances of abuse, neglect and exploitation violations. The Quality Review Team (QRT), made up of DMAS and DBHDS staff, reviews information from CHRIS quarterly regarding individuals served by this waiver.

DMAS is responsible for monitoring the report of and response to critical incidents/events affecting individuals receiving this waiver through a review of reports provided by DARS. These reports are reviewed on a quarterly basis by the QRT and examine investigations of critical incidents, i.e., incidents of neglect, self-neglect, physical abuse, mental abuse, sexual abuse, financial exploitation, other exploitation and the percentage of individuals who accepted and refused protective services. The data collected will be reviewed and analyzed to identify trends. Any trends noted will be used to provide information for future training and provider development.

The QRT also reviews reports from the DBHDS Mortality Review Committee of deaths of individuals receiving services from DBHDS-licensed providers.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

● **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The human rights regulations define restrictions as anything that limits or prevents an individual from freely exercising his rights and privileges. Restrictions on Freedom of everyday life are outlined in 12 VAC35-115-100. The use of seclusion, restraint and time out is outlined in 12VAC35-115-110. Restraints (defined in regulation as the use of a mechanical device, medication, physical intervention or hands-on hold to prevent an individual from moving his body to engage in a behavior that places him or others at imminent risk" [12 VAC 35-115-30]) may only be used in an emergency or when recommended by a qualified professional ("Providers may use restraint in a behavioral treatment plan to address behaviors that present an immediate danger to the individual or others, but only after a licensed professional has conducted a detailed and systematic assessment of the behavior and the situations in which the behavior occurs." [12 VAC 35-115-105])

DBHDS encourages the use of evidence based positive behavioral supports to support individuals with challenging behaviors over more restrictive interventions ("Providers shall not use . . . restraint for any behavioral, medical or protective purpose unless other less restrictive techniques have been considered and documentation is placed in the individual's services plan that these less restrictive techniques did not or would not succeed in reducing or eliminating behaviors that are self-injurious or dangerous to other people or that no less restrictive measure was possible in the event of a sudden emergency." [12 VAC 35-115-110])

Parameters for the use of restraints are detailed in the DBHDS Human Rights regulations (12 VAC 35-115-110) and the DBHDS Licensing regulations (12 VAC 35-105-830) and include:

* Providers shall not use restraint as a punishment or reprisal or for the convenience of staff.
* Providers shall not use restraint solely because criminal charges are pending against the individual.
* Providers shall not use restraint for any behavioral, medical or protective purpose unless other less restrictive techniques have been considers and the service plan includes documentation that these less restrictive techniques did not or would not succeed in reducing or eliminating behaviors that are self-injurious or dangerous to other people or that no less restrictive measure was possible in the event of a sudden emergency.
* Providers that use restraint shall develop written policies and procedures (to be reviewed by Office of Licensing staff) that comply with applicable federal and state laws and regulations.
* Providers shall submit all proposed restraint and time out policies and procedures to the DBHDS Human Rights Advocate and upon request to the Local Human Rights Committee for review and comment .
* Application of restraint shall be documented in the individual's record and, at a minimum, include physician's order, date and time, employees involved, circumstances and reasons for use, duration, type of technique used and outcomes.

Pharmacological restraints would NOT be appropriate in this waiver's venues. Therefore, providers may ONLY employ:
* mechanical restraints, which is defined as "the use of a mechanical device that cannot be removed by the individual to restrict the freedom of movement or function of a limb or portion of an individual's body when that behavior places him or others at imminent risk," [12 VAC 35-115-30] or
* physical restraints (also referred to as "manual hold") which is defined as "the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.""[12 VAC 35-115-30]

Providers must have a written policy that states who is qualified/trained to implement any restraint or time out ("Providers that use . . . restraint shall develop written policies and procedures that comply with applicable federal and state laws and regulations . . . and sound therapeutic practice. These policies and procedures shall include . . . trained, qualified staff shall monitor the individual's medical and mental condition continuously while the restriction is being used."[12 VAC 35-115-110]). Further, regulations state that, "Providers shall ensure that only staff who have been trained in the proper and safe use of . . . restraint techniques may initiate, monitor and discontinue their use."" [12 VAC 35-115-110]. In addition, the Office of Licensing requires that, "The use . . . shall be consistent with the provider's policies and procedures."

Providers implementing physical restraints generally have staff trained in using the system: Mandt, Therapeutic Options, Crisis Waive, or Nonviolent Crisis Interventions (CPI). Providers implementing a mechanical restraint (most commonly the protective wearing of a helmet, glove or mitten) must have staff

trained by the appropriate professional to administer whatever restrictive device/procedure according to the needs of the individual and as defined in policy. Ideally, as staff are trained to recognize the individual's cues as to when the restraint or time out is needed, so should they work with the individual to help him recognize when he needs the protective device/time apart from others so that he can self-administer (at that point the device/removal ceases to be a restraint/time out, as "the voluntary use of protective equipment [is] not considered restraints." [12 VAC 35-115-110]

In addition to the safeguards mentioned above, human rights regulations state the following:
"Each individual is entitled to be completely free from any unnecessary use of . . . restraint."

The provider's duties [regarding the use of restraint include]:
1. Providers shall meet with the individual or his authorized representative upon admission to the service to discuss and document in the individual's services record, his preferred interventions in the event his behaviors or symptoms become a danger to himself or others and under what circumstances, if any, the intervention may include restraint.

2. Providers shall document in the individual's services record all known contraindications to the use of . . . any form of physical or mechanical restraint including medical contraindications and a history of trauma and shall flag the record to alert and communicate this information to staff.

3. Individuals shall be given the opportunity for motion and exercise, to eat at normal meal times and take fluids to use the restroom and to bathe as needed.

4. Each use of restraint shall end immediately when criteria for removal are met.

5. Providers shall ensure that a qualified professional who is involved in providing services to the individual reviews every use of physical restraint as soon as possible after it is carried out and documents the results of his review in the individual's services record.

6. Providers shall ensure that review and approval by a qualified professional for the use or continuation of restraint for medical or protective purposes is documented in the individual's services record. Documentation includes:
  a. Justification for any restraint
  b. Time-limited approval for the use or continuation of restraint; and
  c. Any physical or psychological conditions that would place the individual at greater risk during restraint.

7. Providers may use . . . mechanical restraint for behavioral purposes in an emergency only if a qualified professional involved in providing services to the individual has, within one hour of the initiation of the procedure:
  a. conducted a face-to-face assessment of the individual and documented that alternatives to the proposed use of . . . mechanical restraint have not been successful in changing the behavior or were not attempted, taking into account the individuals' medical and mental condition, behavior, preferences, nursing and medication needs and ability to function independently;
  b. determined that the proposed . . . mechanical restraint is necessary to protect the individual or others from harm injury or death;
  c. documented in the individual's services record the specific reason for the . . . mechanical restraint;
  d. documented in the individual's services record the behavioral criteria that the individual must meet for release from . . . mechanical restraint; and
  e. explained to the individual, in a way that he can understand, the reason for using mechanical restraint . . ., the criteria for its removal, and the individual's right to a fair review of whether the mechanical restraint . . . was permissible.

8. Providers shall limit each approval for restraint for behavioral purposes . . . to four hours for individuals age 18 and older, two hours for children and adolescents ages 9 to 17 and one hour for children under age nine.

9. Providers shall not issue standing orders for the use of . . . restraint for behavioral purposes.

10. Providers shall ensure that no individual is in time out for more than 30 minutes per episode.

11. Providers shall monitor the use of restraint for behavioral purposes . . . through continuous face-to-face observation, rather than by an electronic surveillance device." [12 VAC 35-115-110]

Each instance of restraint shall be compiled on a monthly basis and the report shall include:
• Type(s) (physical restraint or mechanical restraint)
• Rationale for the use of restraint (behavioral purpose, medical purpose or protective purpose).
• Duration of the restraint.

Providers shall submit an annual report of each instance of restraint and seclusion by the 15th of January each year or more frequently if requested by DBHDS. Each instance of restraint or seclusion shall be compiled on a monthly basis and available for review by DBHDS as requested. The DBHDS Computerized Human Rights Information System (CHRIS) captures use of restraints that result in allegations of abuse or neglect.

DBHDS human rights regulations require that providers report to the Human Rights Advocate (an employee of DBHDS) the use of any restraint not included in their policies or permitted by regulation ("Any instance of . . . restraint that does not comply with these regulations or approved variances, or that results in injury to an individual, shall be reported to the authorized representative, as applicable, and the assigned human rights advocate within 24 hours." [12 VAC 35-115-230])

If it is discovered through a DBHDS Licensing or Human Rights review of a provider's services or individual/employee report that an unauthorized use of restraints (or any use of seclusion) occurred and was not properly reported, the provider will be required to develop a corrective action plan and may face additional sanctions.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DBHDS Office of Licensing and Human Rights are responsible for overseeing the use of restraints in DBHDS-licensed programs. Providers that use restraint shall develop written policies and procedures (to be reviewed by Office of Licensing staff prior to the issuance of a license) that comply with applicable federal and state laws and regulations. .

This responsibility is shared by DBHDS and DMAS. The DBHDS Office of Licensing, Office of Human Rights, and DMAS Quality Management Review staff visit providers onsite on an on-going basis to examine records and may talk to staff and individuals receiving services to determine unauthorized use of restraints.

Approaches Used to Detect Unauthorized Use of Restraint and Other Restrictive Interventions

A. Providers shall notify the department whenever a regulatory, accreditation or certification agency or third party payer identifies problems in the provider's compliance with any applicable restraint standard

B. Individuals receiving services or their authorized representatives have a right to complain that the provider has violated any of their rights, including violations of regulations governing the use of restraint.

C. All employees of a provider must, as a condition of employment report all suspected abuse or neglect to the director, including acts such the use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice, or the person's individualized plan; use of more restrictive services to punish the person or that is not consistent with the individualized service plan; the failure to comply with standards related to monitoring, motion and exercise, meals, fluid intake, use of restroom and bathing.

D. Whenever abuse or neglect are reported: (1) the provider investigates the allegation and makes a determination as to whether the allegation is substantiated, (2) the Human Rights Advocate reviews the findings of the provider's investigation and ensures that its corrective action plan is implemented, as appropriate.

E. The DBHDS Quality Improvement Committee quarterly reviews aggregate data related to the use of alleged and founded abuse and neglect, including abuse and neglect related to the use of restraint and other restrictive procedures.

A Local Human Rights Committee (LHRC) is a group of at least five people appointed by the State Human Rights Committee (SHRC). At least two members are individuals who are receiving, or have received within 5 years of their appointment, Mental Health, Developmental Disability or Substance Abuse services. At least one member must be a health care provider. At least one-third of the members are individuals or family members of individuals. The remaining appointments include persons with interest, knowledge or training in the MH, DD or SA field. There are numerous LHRCs statewide. All DBHDS-licensed providers are required comply with requests of the LHRC to investigate and correct conditions or practices that interfere with the free exercise of individuals' human rights. In this way, there is Virginia citizen oversight of these providers and assurance to the community that DBHDS-licensed providers are held accountable for respecting the human rights of those they support.

LHRCs are required to meet at least quarterly and are responsible for:
1. review of any restriction on the dignity rights of any individual imposed pursuant to 12VAC35-115-100 or freedoms of everyday life pursuant to 12VAC35-115-100 that lasts longer than 7 days or is imposed 3 or more times in a 30 day period,
2. review of provider policies, procedures, practices or behavior plans that could jeopardize the rights of individuals receiving services from that provider,
3. review any behavioral treatment plan that involves the use of restraint or time out, and its independent review committee approval to determine whether the plan is in accordance with the Human Rights Regulations prior to implementation,
4. review behavioral treatment plans involving use of restraint and time out quarterly to determine if the use of restraint has resulted in improvements in functionality of the individual.

If the LHRC finds that a provider's plan violates or has the potential to violate the rights of the individual, the LHRC shall notify and make recommendation to the director of the Office of Human Rights.

The process of oversight includes the following chain of command: all meetings of LHRCs are attended by a Human Rights Advocate (DBHDS staff), who reports to the state Director of Human Rights, who is a member of the DMAS-DBHDS Quality Review Team and can thus relay information to the Medicaid agency at that meeting and at other appropriate junctures.

The Office of Human Rights relies on provider self-report through the DBHDS Computerized Human Rights Information System (CHRIS) within 24 hours of any use of restraint that does not comply with the regulations or approved variances or that results in injury to an individual.

Detection of inappropriate/ineffective, misapplication or unauthorized use of restraints may also occur in the context of a Licensing, Human Rights or DMAS Quality Management Review on-site review of the provider's services. Such events would warrant a plan of correction.

Should a human rights violation complaint be filed by an individual or his/her representative, the provider is responsible for providing to the Human Rights Advocate information on the type, resolution level and findings of the complaint.

Per 12 VAC 35-115-230, DBHDS licensed providers shall submit an annual report of each instance of restraint by the 15th of January each year, or more frequently if requested by DBHDS. Each instance of restraint shall be compiled on a monthly basis and the report shall include:

a. The type(s) of restraint employed (e.g., physical or mechanical);
b. The rationale for the use of restraint (e.g., behavioral purpose, medical purpose, protective purpose); and
c. The duration of the restraint.

In addition, the QRT monitors, through data collected from DBHDS Offices of Licensing and Human Rights, providers that are cited for abuse as a result of unauthorized use of restraints.

DMAS is responsible for monitoring the reporting of and response to critical incidents and events affecting waiver individuals through a review of reports provided by VDSS, as detailed in G-1-e. DMAS also participates (through the QRT) in a discussion of DBHDS Human Rights and Office of Licensing findings.

All providers are required to collect and maintain on a monthly basis, and report at least annually to the DBHDS the following information concerning the use of each instance of restraint:

a. Type of restraint to include physical restraint (manual hold), mechanical restraint, and pharmacological restraint
b. Rational for use to include, behavioral purpose, medical purpose or protective purpose
c. Duration of restraint used. Duration for behavioral purposes is defined as the actual time the individual is in restraint from the time of initiation of restraint until the time the individual is released. Duration of restraint for medical and protective purposes is defined as the length of the episode as indicated in the order.

Providers shall report each instance of restraint that does not comply with the human rights regulations or approved variance that result in injury to an individual to the individual's authorized representative and the assigned Human Rights Advocate within 24 hours.

Providers shall report each instance of serious injury resulting from the use of restraint to the department's assigned Licensing Specialist with 24 hours of discovery and by phone to the individual's authorized representative.

Quality Improvement: The state's Office of Human Rights (OHR) uses the DBHDS Data Warehouse to compile and review data based on abuse/neglect reports entered by providers in CHRIS [state reporting system]. Advocates review reports daily while OHR leadership reviews reports weekly, monthly and quarterly based on Region, Service Type, Provider, Individual and other indicators to determine trends and

patterns.

OHR uses the licensing citation process as well as 1:1 training and consultation to encourage and assist providers in developing and implementing improvement (i.e. restraint reduction) strategies.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

● **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The following restrictive interventions/actions are prohibited in DBHDS-licensed settings [12 VAC 35-105-820]:

1. Prohibition of contacts and visits with attorney, probation officer, placing agency representative, minister or chaplain;
2. Any action that is humiliating, degrading, or abusive;
3. Subjection to unsanitary living conditions;
4. Deprivation of opportunities for bathing or access to toilet facilities except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record;
5. Deprivation of appropriate services and treatment;
6. Deprivation of health care;
7. Administration of laxatives, enemas, or emetics except as ordered by a physician or other professional acting within the scope of his license for a legitimate medical purpose and documented in the individual's record;
8. Limitation on contacts with regulators, advocates or staff attorneys employed by the department or the Virginia Office for Protection and Advocacy.
9. Deprivation of drinking water or food necessary to meet an individual's daily nutritional needs except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record;
10. Prohibition on contacts and visits with family or an authorized representative except as permitted by other applicable state regulations or by order of a court of competent jurisdiction;
11. Delay or withholding of incoming or outgoing mail except as permitted by other applicable state and federal regulations or by order of a court of competent jurisdiction; and
12. Deprivation of opportunities for sleep or rest except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record.
13. Applications of aversive stimuli except as permitted pursuant to other applicable state regulations.

The use of time out (defined as the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior) is permitted. Parameters for its use are detailed in the DBHDS Human Rights regulations (12 VAC 35-115-110) and the DBHDS Licensing regulations (12 VAC 35-105-830) and include:

1. Providers shall not use seclusion, restraint, time out as a punishment or reprisal or for the convenience of staff.
2. Providers shall not use seclusion or restraint for any behavioral, medical or protective purpose unless other less restrictive techniques have been considered and the ISP includes documentation that these less restrictive techniques did not or would not succeed in reducing or eliminating behaviors that are self-injurious or dangerous to other people or that no less restrictive measure was possible in the event of a sudden emergency.
3. Providers that use seclusion, restraint, or time out shall develop written policies and procedures (to be reviewed by Office of Licensing staff in the initial application) that comply with applicable federal and state laws and regulations.
4. Use of time out, seclusion, or restraint shall be documented in the individual's record and at a minimum includes:
   a. Physician's order;
   b. Date and time;
   c. Employees or contractors involved;
   d. Circumstances and reasons for use, including but not limited to other behavior management techniques attempted;
   e. Duration;
   f. Type of technique used; and
   g. Outcomes, including documentation of debriefing of the individual and staff involved following the incident.

Restrictive procedures are only to be used in an emergency or when recommended by a qualified professional ("Providers may use time out in a behavioral treatment plan to address behaviors that present an immediate danger to the individual or others, but only after a licensed professional has conducted a detailed

systematic assessment of the behavior and the situations in which the behavior occurs" [12 VAC 35-115-105]). DBHDS strongly encourages the use of a proactive behavioral approach to handling challenging behavior over more restrictive procedures. "Each individual is entitled to be completely free from any unnecessary use of . . . time out." [12 VAC 35-115-110]

Providers must have a policy to state who is qualified/trained to implement time out ("Providers that use . . . time out shall develop written policies and procedures that comply with applicable federal and state laws and regulations . . . and sound therapeutic practice. These policies and procedures shall include . . . trained, qualified staff shall monitor the individual's medical and mental condition continuously while the restriction is being used." [12 VAC 35-115-110]). Further, regulations state that, "Providers shall ensure that only staff who have been trained in the proper and safe use of . . . time out techniques may initiate, monitor and discontinue their use." [12 VAC 35-115-110]

The providers' duties I suggest updating this to the new regulatory language listed below:
The provider's duties.
1. Providers shall meet with the individual or his authorized representative upon admission to the service to discuss and document in the individual's services record his preferred interventions in the event his behaviors or symptoms become a danger to himself or others and under what circumstances, if any, the intervention may include seclusion, restraint, or time out.
2. Providers shall document in the individual's services record all known contraindications to the use of seclusion, time out, or any form of physical or mechanical restraint, including medical contraindications and a history of trauma, and shall flag the record to alert and communicate this information to staff.
3. Only residential facilities for children that are licensed under the Regulations for Children's Residential Facilities (12VAC35-46) and inpatient hospitals may use seclusion and only in an emergency.
4. Providers shall not use seclusion, restraint, or time out as a punishment or reprisal or for the convenience of staff.
5. Providers shall not use seclusion or restraint solely because criminal charges are pending against the individual.
6. Providers shall not use a restraint that places the individual's body in a prone (face down) position.
7. Providers shall not use seclusion or restraint for any behavioral, medical, or protective purpose unless other less restrictive techniques have been considered and documentation is placed in the ISP that these less restrictive techniques did not or would not succeed in reducing or eliminating behaviors that are self-injurious or dangerous to other people or that no less restrictive measure was possible in the event of a sudden emergency.
8. Providers that use seclusion, restraint, or time out shall develop written policies and procedures that comply with applicable federal and state laws and regulations, accreditation and certification standards, third party payer requirements, and sound therapeutic practice. These policies and procedures shall include at least the following requirements:
a. Individuals shall be given the opportunity for motion and exercise, to eat at normal meal times and take fluids, to use the restroom, and to bathe as needed.
b. Trained, qualified staff shall monitor the individual's medical and mental condition continuously while the restriction is being used.
c. Each use of seclusion, restraint, or time out shall end immediately when criteria for removal are met.
d. Incidents of seclusion and restraint, including the rationale for and the type and duration of the restraint, shall be reported to the department as provided in 12VAC35-115-230 C.
9. Providers shall comply with all applicable state and federal laws and regulations, certification and accreditation standards, and third party requirements as they relate to seclusion and restraint.
a. Whenever an inconsistency exists between this chapter and federal laws or regulations, accreditation or certification standards, or the requirements of third party payers, the provider shall comply with the higher standard.
b. Providers shall notify the department whenever a regulatory, accreditation, or certification agency or third party payer identifies problems in the provider's compliance with any applicable seclusion and restraint standard.
10. Providers shall ensure that only staff who have been trained in the proper and safe use of seclusion, restraint, and time out techniques may initiate, monitor, and discontinue their use.
11. Providers shall ensure that a qualified professional who is involved in providing services to the individual reviews every use of physical restraint as soon as possible after it is carried out and documents the results of

his review in the individual's services record.
12. Providers shall ensure that review and approval by a qualified professional for the use or continuation of restraint for medical or protective purposes is documented in the individual's services record. Documentation includes:
a. Justification for any restraint;
b. Time-limited approval for the use or continuation of restraint; and
c. Any physical or psychological conditions that would place the individual at greater risk during restraint.
13. Providers may use seclusion or mechanical restraint for behavioral purposes in an emergency only if a qualified professional involved in providing services to the individual has, within one hour of the initiation of the procedure:
a. Conducted a face-to-face assessment of the individual placed in seclusion or mechanical restraint and documented that alternatives to the proposed use of seclusion or mechanical restraint have not been successful in changing the behavior or were not attempted, taking into account the individual's medical and mental condition, behavior, preferences, nursing and medication needs, and ability to function independently;
b. Determined that the proposed seclusion or mechanical restraint is necessary to protect the individual or others from harm, injury, or death;
c. Documented in the individual's services record the specific reason for the seclusion or mechanical restraint;
d. Documented in the individual's services record the behavioral criteria that the individual must meet for release from seclusion or mechanical restraint; and
e. Explained to the individual, in a way that he can understand, the reason for using mechanical restraint or seclusion, the criteria for its removal, and the individual's right to a fair review of whether the mechanical restraint or seclusion was permissible.
14. Providers shall limit each approval for restraint for behavioral purposes or seclusion to four hours for individuals age 18 and older, two hours for children and adolescents ages nine through 17, and one hour for children under age nine.
15. Providers shall not issue standing orders for the use of seclusion or restraint for behavioral purposes.
16. Providers shall ensure that no individual is in time out for more than 30 minutes per episode.
17. Providers shall monitor the use of restraint for behavioral purposes or seclusion through continuous face-to-face observation, rather than by an electronic surveillance device.

Definitions:
"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.
2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.
3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Time out" is defined as the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Seclusion" is defined as the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means, so that the individual cannot leave it.

If conducted in accordance with the regulations, "time out" is not "seclusion". When time out is used, there should be no verbal directive or physical barrier preventing the individual to leave. The language dictating the proper use of "time out" is noted below:

12VAC35-115-105 B: Providers may use individualized restrictions such as restraint or time out in a behavioral treatment plan to address challenging behaviors that present an immediate danger to the individual or others, but only after a licensed professional has conducted a detailed and systematic assessment of the behavior and the situations in which the behavior occurs. Providers shall document in the individual's services record that the lack of success or probable success of less restrictive procedures attempted or considered, and the risks associated with not treating the behavior, are greater than any risks associated with the use of the proposed restrictions.

DBHDS relies largely on self-reporting to detect any unauthorized use of time out and other restrictive procedures. Reports are typically made to the Human Rights Advocate through the DBHDS web based reporting system known as CHRIS. This is also monitored by site visits by Office of Licensing and Human Rights staff. If it is discovered through a DBHDS Licensing or Human Rights review of a provider's services or individual/employee report that a restrictive intervention was employed that conflicts with Licensing or Human Rights regulations, the provider will be required to develop a corrective action plan and may face additional sanctions.

In addition, DBHDS employs a contractor (Health Services Advisory Group) to conduct on-site "Person Centered Reviews" and "Provider Quality Reviews" throughout the year. Health Services Advisory Group reports all instances of restrictive interventions (including restraints and seclusion) noted to DBHDS. Each quarter the OHR Director or designee will receive and review each incident in the above mentioned report. Any incident of seclusion, as defined in 12 VAC35-115-110, that's identified will be forwarded to the regional manager for immediate investigation and possible citation for human rights violation.

While self-report is a critical element of the Commonwealth's safeguards of this aspect, per G.2.aii, "The DBHDS Office of Licensing, Office of Human Rights, and DMAS Quality Management Review staff visit providers onsite on an on-going basis to examine records and may talk to staff and individuals receiving services to determine unauthorized use of restraints." Per G.2.a.i, "If it is discovered through a DBHDS Licensing or Human Rights review of a provider's services or individual/employee report that an unauthorized use of restraints (or any use of seclusion) occurred and was not properly reported, the provider will be required to develop a corrective action plan and may face additional sanctions." QMR would also result in a corrective action plan and report to DBHDS for follow-up. These on-site reviews by DBHDS and DMAS staff are a means to identify unauthorized use of restrictive interventions. Information about unauthorized use of restrictive interventions is also collected by the DBHDS contractor Health Services Advisory Group, reported to DBHDS and then acted upon.

The use of restrictive interventions is also reviewed by DMAS Quality Management Review staff as they conduct on-site visits. Unapproved/inappropriate uses (e.g., lack of staff training, lack of appropriate procedures, failure to follow established procedures) result in a required corrective action plan for the provider.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The state agencies responsible for overseeing the use of restrictive interventions in DBHDS-licensed agencies are the DBHDS Office of Licensing and Office of Human Rights. Representatives of both of these offices participate on the Quality Review Team with DMAS and thus communicate at least quarterly through that forum. The DBHDS Office of Licensing, Office of Human Rights, and DMAS Quality Management Review staff, visit providers onsite to examine records, and may talk to staff and individuals receiving services to determine unauthorized use of restraints.

Providers that use seclusion, restraint, or time out shall develop written policies and procedures (to be reviewed and approved by DBHDS Office of Licensing staff) that comply with applicable federal and state laws and regulations. In addition, providers shall submit all proposed time out policies and procedures to the Human Rights Advocate for review at the initial new provider site visit and comment when proposing changes or upon request. LHRCs are required to meet at least quarterly. If the LHRC finds that a provider's plan violates or has the potential to violate the rights of the individual, the LHRC shall notify and make recommendation to the program director.

DBHDS relies largely on self-reporting to detect any unauthorized or inappropriate use of restrictive procedures. This is also monitored by regular site visits by Office of Licensing and Human Rights staff. If it is discovered through a DBHDS Licensing or Human Rights review of a provider's services or individual/employee report that any of the regulatory safeguards concerning the use of time out were not followed, the provider will be required to develop a corrective action plan and may face additional sanctions. DMAS Quality Management Review staff also monitor incidents of the use of restrictive interventions in completing on-site provider reviews. These are delineated as approved/appropriate or unapproved/inappropriate. The latter are reported to DBHDS Office of Licensing and also result in the requirement that the provider submit a corrective action plan.

DMAS does not pay for devices used for the purpose of restraint.

Approaches Used to Detect Unauthorized Use of Restraint and Other Restrictive Interventions

A. Providers shall notify DBHDS whenever a regulatory, accreditation or certification agency or third party payer identifies problems in the provider's compliance with any applicable restraint standard

B. Individuals receiving services or their authorized representatives have a right to complain that the provider has violated any of the rights, including violations of regulations governing the use of restraint.

C. All employees of a providers must, as a condition of employment report all suspected abuse or neglect to the director, including acts such the use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice, or the person's individualized plan; use of more restrictive services to punish the person or that is not consistent with the individualized service plan; the failure to comply with standards related to monitoring, motion and exercise, meals, fluid intake, use of restroom and bathing.

D. Whenever abuse or neglect are reported:
(1) advocates monitor, review, consult and investigate, as appropriate, and
(2) a trained investigator, investigates the allegation and makes recommendations to the provider.

The state's OHR collects data the following ways: 1. The DBHDS Computerized Human Rights Information System (CHRIS) captures use of restraints that result in allegations of abuse or neglect. 2. Per 12VAC35-115-230(C) Providers shall submit an annual report of each instance of restraint and seclusion by the 15th of January each year by DBHDS. 3. Per 12VAC35-115-230(C)Each instance of restraint shall be compiled on a monthly basis and available for review by DBHDS as requested.
OHR uses the DBHDS Data Warehouse to compile and review data daily, weekly, monthly and quarterly. Substantiated allegations of abuse (unauthorized use of restraint) are mitigated via licensing citation - issued directly through CONNECT by the Advocate
OHR offers live web-based training quarterly and as needed to providers concerning regulatory requirements for use of restraint. OHR also reviews all New Provider Behavioral Intervention/Restraint policies during the

licensure process.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- [x] **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Providers of services through this waiver are NOT permitted to use seclusion. Because of this, any use of seclusion is viewed as abuse and must be reported as such electronically through the Computerized Human Rights Information System (CHRIS). In order to identify cases for review by OHR, search terms have been established to qualitatively screen the complaints and abuse allegations data in CHRIS in an automated manner (via SQL code). By design, the dataset to be screened by OHR will include false positives as to decrease the probability of missing potential cases. Each quarter the OHR will receive and review a report from the above screening. Any incident of seclusion, as defined in 12 VAC35-115-110, that is identified will be forwarded to the Office of Human Rights Regional Manager for immediate investigation and possible citation for human rights violation.

If, during the course of regular site visits made to providers by staff with DBHDS Offices of Licensing and Human Rights or through individual or provider staff report, it is discovered that a provider has used seclusion, the provider will be required to develop a corrective action plan and may face additional sanctions. DMAS Quality Management Review staff also look for evidence of the unauthorized use of seclusion in completing on-site provider reviews. If detected, such instances are reported to DBHDS Office of Licensing and Office of Human Rights, and the provider is required to submit to DMAS a corrective action plan.

- [ ] **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix

does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ● **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The licensed provider is required to monitor medication administration errors and develop quality assurance activities in relation to medication errors In Virginia, DBHDS-licensed providers responsible for medication administration and storage shall provide in-service training to employees and consultation to individuals and authorized representatives on issues of basic pharmacology including medication side effects. Staff should be familiar with that information and observant for signs of deleterious side effects. In addition, staff who administer medications are required to learn about side effects as part of the mandatory medication administration training contained in the Board of Nursing Regulations 18VAC90-21-10 through 18VAC90-21-40. Providers shall report such errors in the DHBDS Computerized Human Rights Information System (CHRIS) if licensed medical attention is received. The DBHDS Office of Human Rights would then review and monitor this information if the error is being investigated by the provider as neglect.

Licensing regulation 12VAC35-105-620 requires providers to review medication errors at least quarterly as part of the providers quality improvement plan. The quality improvement plan is subject to audit from the state's Office of Licensing.

The DBHDS Office of Licensing conducts monitoring of medication administration during annual inspections of each provider. The Office of Licensing will take negative action (i.e., issue a provisional license or even pursue the revocation of a provider's license) against a provider due to a pattern of serious, medication related issues. Medication toxicity is considered an injury to the body and, as such, is a reportable event under the Human Rights regulations.

Similarly, DMAS QMR staff are trained to look critically at situations in which individuals are prescribed medications for behavioral reasons or have multiple medications prescribed. These scenarios are reported back to the QMR supervisor for referral to DMAS's Medical Director for additional perspective and guidance.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

DBHDS Office of Licensing staff monitors medication regimens when they conduct their on-site provider reviews. Unannounced inspections may also occur in response to complaints or reports of serious incidents or events. Should potentially harmful practices be identified, the provider is required to develop a Corrective Action Plan and submit it to the reviewing agency. Very serious findings regarding medication practices may lead to a provisional license, which entails monthly monitoring of the provider by Office of Licensing staff. Failure to resolve the issues that led to the provisional license will result in pursuit of license revocation. A provider may hold no more than two consecutive provisional licenses of six months duration each before action to pursue revocation of that license is pursued.

DMAS Quality Management Reviews (QMR) are conducted on a random sample of providers throughout the year. QMR are structured to be completed, with data collected and analyzed, on a quarterly basis. The expected sample size is divided accordingly into quarterly amounts. DMAS may take action to terminate the DMAS provider agreement as a result of its own reviews or the revocation of a provider's license.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DBHDS-licensed providers may administer medication. All medications shall be administered in accordance with the physician's instructions and the provider shall document all medications administered, including over-the-counter medications. Licensing regulations [12 VAC 35-105-770 through 12 VAC 35-105-790] require each provider to develop and implement written policies addressing:

-the safe administration, handling, storage and disposal of medications;
-the use of medication orders;
-the handling of packaged medications brought by individuals from home/other residences;
-employees or contractors who are authorized to administer medication and training required for administration of medication (a Virginia Board of Nursing approved Medication Administration Curriculum is required in accordance with 18 VAC 90-21-10 to 40);
-the use of professional samples; and
-the window within which medications can be given in relation to the ordered time of administration.

The provider must maintain a daily log of all medicines received and refused by each individual. This log shall identify the staff who administered the medication, the name of the medication and dosage administered or refused, and the time the medication was administered or refused.

Virginia Department of Health licensed providers of personal assistance and respite services may administer medication. Direct support staff are monitored by a registered nurse, licensed to practice in the Commonwealth of Virginia The RN is required to provide monthly supervision and oversight to the personal or respite assistant in regards to medication administration, as well as other tasks.

Consumer-directed personal assistance or respite employees may assist with the administration of medication that would typically be self-administered, but because of a disability, they are unable to do so. The individual must be able to supervise and direct the attendant in how to administer the medication. This is monitored by the services facilitator (until 5/31/27) and/or support broker (starting 3/1/27) , who is required to either be a registered nurse or establish a relationship with the individual's primary care provider in order to review medical concerns, including medication.

State policy requires that all nonmedical provider personnel responsible for medication administration successfully complete the 32 hour medication course in accordance with the Board of Nursing Regulations 18VAC90-21-10 through 40. Upon completion of the course, personnel who administer medications or supervise self-administration of medication must pass a written and practical exam at the conclusion of training that measures minimum competency in medication administration.

The curriculum shall include a minimum of 32 hours of classroom instruction and practice in the following:

1. Preparing for safe administration of medications to individuals in specific settings by:
  a. Demonstrating an understanding of the individual's rights regarding medications, treatment decisions and confidentiality.
  b. Recognizing emergencies and other health-threatening conditions and responding accordingly.
  c. Identifying medication terminology and abbreviations.

2. Maintaining aseptic conditions by:
  a. Implementing universal precautions.
  b. Insuring cleanliness and disinfection.
  c. Disposing of infectious or hazardous waste.

3. Facilitating individual self-administration or assisting with medication administration by:
  a. Reviewing administration records and prescriber's orders.
  b. Facilitating individual's awareness of the purpose and effects of medication.

c. Assisting the individual to interpret prescription labels.
d. Observing the five rights of medication administration and security requirements appropriate to the setting.
e. Following proper procedure for preparing medications.
f. Measuring and recording vital signs to assist the individual in making medication administration decisions.
g. Assisting the individual to administer oral medications.
h. Assisting the individual with administration of prepared instillations and treatments of:
(1) Eye drops and ointments.
(2) Ear drops.
(3) Nasal drops and sprays.
(4) Topical preparations.
(5) Compresses and dressings.
(6) Vaginal and rectal products.
(7) Soaks and sitz baths.
(8) Inhalation therapy.
(9) Oral hygiene products.
i. Reporting and recording the individual's refusal to take medication.
j. Documenting medication administration.
k. Documenting and reporting medication errors.
l. Maintaining client records according to facility policy.
m. Sharing information with other staff orally and by using documents.
n. Storing and securing medications.
o. Maintaining an inventory of medications.
p. Disposing of medications.

4. Facilitating the individual's self-administration or assisting with the administration of insulin. Instruction and practice in the administration of insulin shall be included only in those settings where required by individual needs and shall include:

a. Cause and treatment of diabetes;
b. The side effects of insulin;
c. Preparation and administration of insulin; and
d. Signs of severe hypoglycemia and administration of glucagon.

5. Facilitating individual self-administration or assisting with the administration of auto-injectable epinephrine pursuant to an order issued by the prescriber for a specific individual in a facility licensed by DBHDS under the provisions of subsection D of section 54.1-3408 of the Code of Virginia.

6. Pursuant to subsection L of § 54.1-3408 of the Code of Virginia, the board requires successful completion of the curriculum approved by the DBHDS for unlicensed persons to administer medication via a gastrostomy tube to a person receiving services from a program licensed by the DBHDS.

- **Medication Error Reporting.** *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

DBHDS-licensed providers are required to record the following medication errors:
(1) the wrong medication is given to an individual,
(2) the wrong individual is given the medication,
(3) the wrong dosage is given to an individual,
(4) medication is given to an individual at the wrong time or not at all, or
(5) the proper method is not used to give the medication to the individual.

In the event of medication errors or adverse drug reactions in DBHDS-licensed agencies, regulations [12 VAC 35-105-780] require that:

-first aid shall be administered if indicated;
-employees or contractors shall promptly contact a poison control center, pharmacist, nurse or physician and take actions as directed;
-the individual's physician shall be notified as soon as possible unless the situation is addressed in standing orders;
-actions taken by employees or contractors shall be documented;
-medication errors and adverse drug reactions shall be recorded in the individual's medication log; and
-the provider shall review medication errors at least quarterly.

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

For DBHDS-licensed providers, monitoring of medication administration occurs through the DBHDS Office of Licensing, which reviews each provider agency annually. Licensing specialists review medication administration records at least annually during announced and unannounced reviews. Providers failing to comply with state regulations or their own policies regarding medication administration are cited and must submit and implement corrective action plans.

DMAS Quality Management Review staff also review medication regimens and medication administration records when they conduct on-site provider reviews. Identification of potential harmful practices result in the requirement that the provider develop a corrective action plan to be submitted to DMAS. Very serious findings regarding medication practices may lead to a referral to DBHDS Office of Licensing or Virginia Department of Health, depending on the licensing entity. DMAS may take action to terminate the DMAS provider agreement as a result of its own reviews or the revocation of a provider's license due to egregious health and safety concerns.

Proposed updates to waiver regulations will require providers with a history of noncompliance with regulations, as evidenced by multiple citations by either DBHDS Office of Licensing or DMAS QMR, resulting in the need for a corrective action plan in key identified areas such as health (which could include medication errors), safety, or failure to address the identified needs of the individual, will be required to undergo mandatory training and technical assistance in the specific area(s) of noncompliance. Failure to complete the mandatory training or identified technical assistance may result in referral to DMAS Provider Integrity or termination of the provider's Medicaid participation agreement.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HSW3. # & % of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken. N= # of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken. D= # of unexpected deaths where the cause of death/a factor in the death was potentially preventable.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Mortality Review Committee Data Tracking

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HSW2. Number and percent of substantiated cases of abuse/neglect/exploitation (ANE) for which the required corrective action was verified by DBHDS as being implemented within 90 days. N= Number of substantiated cases of ANE for which the required corrective action was verified by DBHDS as being implemented within 90 days. D= Total number of substantiated cases of ANE.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CHRIS via Data Warehouse

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HSW4. Number and percent of individuals whose service record contains a current notification of rights and information to report ANE. N = Number of individuals whose service record contains a current notification of rights and information to report ANE. D = Number of individuals whose service records were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Service Review (QSR) Contractor

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HSW1. # and % of closed cases of abuse/neglect/exploitation (ANE) for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations. N= Number of closed cases of ANE for which DBHDS verified that the investigation was conducted by the provider was done in accordance with regulations. D= Number of closed cases of ANE that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Office of Human Rights Retrospective Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HSW6. # and % of licensed DD providers that administer medications that weren't cited for failure to review medication errors at least quarterly. N= # of licensed DD providers that administer medications that weren't cited for failure to review medication errors at least quarterly. D= # of licensed DD providers that administer medications that were reviewed by Office of Licensing in the quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBHDS Office of Licensing

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HSW5. # and % of critical incidents reported to the Office of Licensing within the required time frames as specified in the approved waiver. N: Number of critical incidents reported to the Office of Licensing within the required time frame as specified in the approved waiver. D: Number of critical incidents reported to the Office of Licensing regarding individuals receiving DD waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CHRIS via Data Warehouse

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HSW8. Number and percent of individuals who did not have unauthorized seclusion. N: Number of individuals who did not have unauthorized seclusion. D: Number of abuse allegations and complaints submitted via CHRIS.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
CHRIS

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
HSW7. Number and percent of individuals who did not have unauthorized restrictive interventions, including use of restraints. N: Number of individuals who did not have unauthorized restrictive interventions, including use of restraints. D: Number of individuals reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
DBHDS Office of Licensing and Office of Human Rights. DMAS QMR staff will also report incidents to DBHDS staff.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group:

		Representative sample (95% confidence lvl & +/- 5% margin of error) of total CL, FIS, BI waiver enrollees. Using a % of the total each waiver represents, calculation is made for the # for each waiver.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Service Review (QSR) Contractor alerts.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Multifaceted data: individuals receiving services, providers, case managers, family & medical records. Methods- Interviews, observations & Likert scales. Sample: 400 randomly selected 95% confidence
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HSW9. Number and percent of individuals who had a physical examination completed within the past 365 days. N: # of individuals who had a physical examination completed within the past 365 days. D: # of individuals enrolled in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBHDS/Waiver Management System (WaMS)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Subassurance (1) PM # 1's reference to "in accordance with the regulations" includes the following considerations: that the investigation was conducted by a person properly trained to conduct investigations with documentary evidence of witness interviews and/or investigations of other relevant factors, notification with documentary evidence of witness interviews and/or investigations of other relevant factors, notification to the State within 10 working days and a positive determination by DBHDS on the efficacy of findings.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

As DBHDS Office of Licensing or DMAS Quality Management Review (QMR) staff identifies problems with any of the above measures for a given provider, they each require a corrective action plan to be developed and implemented by that provider. Failure to do so jeopardizes the provider's license/Medicaid provider agreement. Serious violations may be referred to DMAS's Provider Integrity unit for payment retraction.

Individual providers with systemic problems will be targeted for technical assistance/training from DBHDS. These events and their results will be documented in a quarterly report of technical assistance provided in response to Office of Licensing and DMAS identified issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Department of Medical Assistance Services (DMAS) Division of High Needs Supports and Office of Community Living, and the Department of Behavioral Health and Developmental Services (DBHDS) divisions of Developmental Services (DDS) and Clinical and Quality Management (CQM) are responsible for oversight and improvement of the quality of services delivered under the DD waivers in the Commonwealth. Performance data is collected across a broad range of monitoring activities, including licensing and human rights investigations and inspections; quality management reviews (QMR); level of care evaluations, serious incident reporting; quality service reviews (QSR); Support Coordinator Quality Reviews (SCQR); and mortality reviews.
Performance measure (PM) data used to support the CMS waiver assurances is reviewed by the Quality Review Team (QRT). At the end of each quarter, the QRT reviews data related to the waiver assurances for VA.0358, VA.0372, and VA.0430. Representatives from various DBHDS and DMAS divisions and departments work collaboratively on the QRT to provide data, discuss barriers to compliance, and present remediation strategies to correct areas of deficiency. The QRT provides an annual report summarizing waiver performance to the DBHDS Quality Improvement Committee (QIC), which is responsible for reviewing the overall quality of community services provided to individuals with DD and making recommendations for system improvements. The QRT is co-led by DMAS and DBHDS and includes staff from DMAS' Division of High Needs Supports, including QMR, and Office of Community Living, as well as the DBHDS' Division of Developmental Services (DDS), Office of Human Rights (OHR), Office of Licensing (OL), Office of Integrated Health (OIH), Office of Provider Development, the Division of Clinical and Quality Management, and the Office of Community Quality Management. When performance of any PM is not meeting the accepted threshold, the team reviews data from the relevant unit noted above for the given PM to determine remediation strategies, monitor progress toward the attainment of the desired performance goal, and change strategies as needed. Each representative unit on the QRT performs a valuable role and function on the team as subject matter expert.
DBHDS OHR
The OHR reports on PMs and other data related to the health and welfare of waiver recipients. This includes alleging abuse, neglect and exploitation, use of seclusion, restraint and restrictive interventions. These are reported through the Computerized Human Rights Information System (CHRIS) and the implementation of corrective action plans are monitored through CHRIS as well. Human Rights Advocates respond to complaints and assist in the resolution process by monitoring provider reporting, reviewing provider investigations and verifying implementation of appropriate corrective actions. Advocates also respond to reports of abuse by conducting independent or joint investigations with other DBHDS offices and/or LDSS APS. In cases where there are violations of the Human Rights Regulations, Advocates recommend citation through the Office of Licensing. The OHR reports on provider investigations conducted during the previous quarter once complaints are resolved and cases closed in CHRIS.
DBHDS OL
The OL conducts scheduled on-site reviews, unannounced inspections, as well as investigations of critical incidents and medication errors of licensed DD providers. At the QRT meeting, the OL reports on provider reviews conducted during the last quarter. These reports address any deficiencies found and plans of correction issued. The OL includes an incident management unit and an investigations unit, which is responsible for the daily review, triage, and follow-up on all reported critical incidents. Follow-up on incidents may include phone contact with the provider and/or individual to ensure immediate protections and health and safety follow-up has occurred, desk review of records and reports, and on-site visits when indicated. The incident management unit works closely with the investigations unit, licensing specialists, and human rights advocates to assure adequate follow-up.
Providers are required to report critical incidents to DBHDS through CHRIS within 24 hours of their identifying or being notified of the incident. Upon review, the incident management unit makes a determination as to whether further follow-up is needed. Any incidents for which there are concerns that the individual or others are at imminent risk are referred for immediate investigation; all deaths of individuals with developmental disabilities are referred to the investigation unit. Other concerns are forwarded to the provider's licensing specialist for follow-up.
DBHDS DDS
The DDS reports on case managers' accurate and timely completion of individuals' VIDES (level of care tool) submitted through the Virginia Waiver Management System and statewide slot allocation reported through state Waiver Slot Assignment Committees.
DBHDS Mortality Review
The Mortality Review Committee (MRC) monitors the mortality among individuals with developmental disabilities who receive Medicaid DD waiver services from a provider licensed by DBHDS. The committee's purpose is to identify and implement system wide quality improvement initiatives to reduce the rate of

preventable deaths in this targeted population. For purposes of the DD waivers' quality improvement activities, the MRC's activities include making the determination as to whether a cause of death or a factor in the death was potentially preventable in order to reduce mortality rates to the fullest extent practicable. Following identification of a potentially preventable death, the MRC will recommend intervention or action to remediate which could include action directed at a specific provider or an action directed at system change. This process generates review and changes in policy and procedure, development of protocols, best practice standards, focused training, and strategies for system improvement. All interventions or actions to remediate must be completed within 90 days of review by the MRC. The follow-up remediation actions taken and the responsible entity are reported to the QRT retrospectively on a quarterly basis.

At least annually, the MRC conducts a trend analysis of mortality data to identify patterns at the individual service-delivery and system levels. The MRC reports its findings to the QIC and the DBHDS Commissioner for further assessment and recommendations.

DBHDS OIH
The OIH assesses the needs and resources available for providing health services and supports to persons with DD and serious mental illness (SMI) throughout the Commonwealth, through the Health Support Network and Long Term Care Services. The OIH Health Support Network identifies gaps in services and supports to immediately improve the quality of care and health of individuals in the DD system. Through its Community Nursing Program, the OIH provides training and remediation to DD waiver providers in health and medical safety protocols and issues monthly health alerts, such as choking and constipation risks, medication administration issues, and information about specific medical conditions or experiences. The Director of the OIH serves as a consultative clinical resource to the QRT in the examination of health-related performance data.

DBHDS Office of Clinical Quality Management
The Office of Community Quality Management (OCQM) oversees and directs community-based quality review processes for DBHDS through contract with an external certified Quality Improvement Organization (QIO). Quality Service Reviews (QSRs) are completed on a sample of providers and individuals receiving DD waiver services and include desk reviews, on-site visits, face-to-face interviews, retrospective record reviews, and/or surveys of individuals receiving services. QSRs are completed to gain information about the quality of services provided and/or to get individual and family input on services provided for making improvements in the service experience and to determine how to improve the array of services provided. Data from the QSR process are presented to DBHDS quality subcommittees, the QIC, the QRT, and other stakeholders. Resulting recommendations are used to identify and implement quality improvement initiatives.

DMAS QMR
The DMAS Quality Management Review team aggregates data associated with waiver PMs from ongoing on-site and desk audit provider reviews. When an issue regarding an individual's services and supports is identified, DMAS takes action at the individual level. For example, if an individual is found not to have had services delivered as required in the ISP, DMAS instructs the provider to re-evaluate the needs of the individual and ensure that services are delivered accordingly. The provider must complete a corrective action plan (CAP) to explain how deficiencies will be remediated. Once a CAP has been received and approved, DMAS will complete a follow-up review to determine if the CAP has been implemented as submitted. If the provider still exhibits noncompliance, another CAP is requested. If the provider is still noncompliant at the time of the second follow-up, the provider is referred to DMAS Program Integrity.
QRT Discovery and Remediation
The information collected from the above sources is presented to the QRT, which reviews this aggregated data, recommends remediation, and monitors for changes in the data over time. Provider and individual specific remediation may include retraining of providers, strengthening health and safety supports for individuals through referral to the OIH, referral to DMAS Provider Integrity for a financial audit/potential payment retraction, change in licensing status, or limiting a provider's ability to accept new referrals.
The QRT also identifies systemic barriers to attainment of the target level of performance for any PM and the steps needed to address them. These remediation steps are in addition to any particular provider or individual remediation. Systemic remediation can include statewide or regional provider training (DBHDS Provider Development staff provide targeted training and technical assistance as part of remediation efforts), regulatory or policy revisions, IT system enhancements for the collection of data, or targeted QMR visits.
Related DBHDS Quality Improvement Efforts/Bodies Related to DD Services:

Quality Improvement Committee (QIC)
The QIC is the designated oversight body for the Quality Improvement Program of the DBHDS. All DBHDS quality committees report to the QIC, which reviews committee recommendations, identifies system-wide needs and prioritizes resources allocated to quality improvement efforts. The QRT, as a DBHDS quality subcommittee, reports data to the QIC annually through an end of year report summarizing PM performance. Using data from all DBHDS quality initiatives, the QIC produces an annual quality report that includes the availability and quality of supports and services, gaps in supports and services, and provides recommendations for improvement.
Regional Quality Councils (RQCs)
Regional Quality Councils (RQCs) for Developmental Disabilities are in each of the five DBHDS regions in Virginia. RQC membership includes DBHDS staff, individuals in services, family stakeholders, CSB case management, Quality Improvement personnel, DD directors, and private waiver service providers. Under the direction of the QIC, the RQCs meet quarterly to receive and analyze state and regional data, identify trends, and develop responsive actions by recommending quality improvement initiatives to the QIC. They also monitor the status of the initiatives and support these targeted efforts. The RQCs, as a delegated DBHDS quality subcommittee, reports annually to the QIC.

Continued on Main-Optional.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Recommendations for system design changes may be made to both the QRT and the QIC through the above-described quality framework. Recommendations are based upon specific performance measure data and, in addition to specific interventions, may also include a timeline for implementation, improvements that are expected to occur, and the specific data that will be measured to assess the effectiveness of system design changes.

The QRT and QIC are responsible for monitoring and assessing quality improvement plans that lead to assuring the successful implementation of system change.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The quality improvement strategy is evaluated on an annual basis by the QRT through the review of performance indicators and data collected regarding remediation success/failure, as well as an assessment regarding the adequacy of the current performance measures. In conducting this review, the QRT incorporates feedback from the DBHDS Quality Assurance process. The annual review and related End of Year Report processes described in H.1.a.i. may result in changes to performance measures, priorities, data collection and/or performance measures, or modifications to committees or the roles of key entities.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

DMAS requires all providers of services to comply with state and federal laws and regulations and holds them accountable for this. While DMAS does not impose an independent audit requirement for participating providers, provider agencies may be required to obtain an independent audit as a part of the licensing process through DBHDS. Some agencies are exempt from licensing according as agencies approved for payment by the DMAS per section 32.1-162.8 of the Code of Virginia. Providers exempt from licensing remain subject to complaint investigations in keeping with state law. The provider is responsible to provide DMAS all documentation that will verify services were rendered as billed. This would entail both medical and personnel records.

DMAS' Medicaid Management Information System (MMIS) is an automated claims processing and review system. The MMIS system has built in controls (system edits) to ensure provider billings are in accordance with state and federal regulations prior to claims being approved for payment. Currently there are over 1,550 system edits in the Virginia MMIS, which rejects duplicate claims, and claims for services or service levels that are not authorized under Medicaid policy as example. As a part of claims processing, DMAS also utilizes two products that consists of regularly-updated system edits which prevent improper payments. These packages are Correct Coding Initiative edits which were developed by CMS and Claim Check, a commercial software product. Changes or updates to the MMIS system edits are submitted on an Information Service Request form and reviewed by a MMIS change committee. Upon approval by the committee, the changes or updates are programmed. The MMIS is updated quarterly to include the CMS updates to the National Correct Coding Initiative (NCCI) edits. Other covered service and service limit system edits are continually updated as needed due to changes to Virginia Medicaid policies.
DMAS ensures financial integrity and accountability through multiple processes occurring across several divisions. The Fiscal and Purchases Division is responsible for the timely and accurate processing and recording of financial transactions to include collection of provider and recipient overpayments The fiscal division is charged with recovering overpayments and verifying proper documentation of the amounts. This division does not perform reviews.

The Internal Audit Division reviews claims for correct billing performing tests on claims in the MMIS for patterns that are anomalies across provider types. The Division focuses on the accurate processing of claims through MMIS to identify possible patterns of fraud, waste abuse. This division uses concurrent auditing of claims to uncover any problems in the waiver, using over 300 checks on a continuous basis before claims are paid. They also review claims after they are paid to identify irregularities in payment patterns.

The Division of Program Integrity conducts financial reviews utilizing internal staff as well as contractors acquired through a competitive procurement process. The Provider Review Unit (PRU) in the Division of Program Integrity investigates allegations of provider waste and abuse that result in overpayments of Medicaid benefits. The PRU receives allegations from providers, state agencies, law enforcement agencies, individuals, and other DMAS units. These allegations typically involve misspent funds involving fee-for-service or managed care provider issues such as: billing for a service using a code that the provider has previously been instructed not to use, billing for more expensive services or procedures than were actually provided or performed (commonly known as up-coding), billing for services that were never rendered, performing medically unnecessary services, and misrepresenting non-covered treatments as medically necessary covered treatments. EVV is not used as part of post-payment review for personal care services. The scope of reviews is based on an audit matrix that is in direct alignment with state and federal regulations and business rules detailed in our provider manuals for each Medicaid service and provider type.

The PRU and DMAS contractors could potentially review any provider group, though all audits are designated to specific provider types and services through an annual comprehensive risk-based audit plan. Each year 10 risk factors are utilized that range from changes in operations to growth in members and dollars paid for all service render under Virginia Medicaid. The audit designates auditing resources based on high risk. On average, 60-65 audits per year by PRU and DMAS contractors are designated specifically for waiver services. The PRU utilizes Fraud Analytic Detection System (FADS). This claims-based data mining software packages is used to determine which providers are exceeding the billing norms for their peer groups. Contractors use proprietary algorithms to select providers to review and claims to review for those providers. For consistency and to prevent provider abrasion, sample sizes are calculated so that 30% - 50% of the paid universe of claims for the review period is audited. This method has been reviewed by APA and CMS and accepted as the necessary sample to meet the required program integrity oversight standards.
The division monitors provider activity; to identify potentially fraudulent or abusive billing practices; and when necessary recommend policy changes to prevent abusive billing practices; and to refer abusive providers to other state agencies. Cases are referred to Medicaid Fraud Control Unit (MFCU) when potentially egregious fraud is identified. The Divisions Sr. Policy Analyst serves as the liaison to the MFCU and is responsible for reviewing and submitting all fraud referrals from DMAS and its contractors. The MFCU determines if the case warrants further investigation as fraud.

The Program Integrity Division and contract auditors conduct almost all reviews as desk reviews of medical and personnel

records to determine if services were provided as billed. In certain cases, such as those where fraud is suspected, record collection will be conducted on-site. In addition to ensuring that services are appropriate and adequately documented, these reviews also determine if the services were provided by qualified staff members.

PRU Cases selected for review are tracked in the FADS case tracking system. Using this data, management reports can be generated detailing the status of each review. Reviews look at a focused sample of records. The sample is selected using all claims of a selection of recipients for a period, with a focus on recipients with claims that are most likely to contain overpayments. After reviewing the records, the PRU Analyst completes the Integrity Review and closes the case if there is no abuse (no billing errors are identified) and send them correspondence indicating such. When billing errors have been identified, an overpayment letter is sent to the provider and recovery is sought regardless of the dollar value. If the provider disagrees, they have the right to appeal.

Overpayments are recovered either by submission of a check from the provider, or through offsets of future provider payments from our MMIS claims payment system.

The provider has four opportunities to provide input to the audit: Response to Preliminary Investigation, Request for an Informal Fact Finding Conference (IFFC), Formal Evidential Hearing, and Circuit Court. All are dictated by State regulations and handled by the Department's Appeals Division.

DMAS and DBHDS undergo an annual independent audit through the Virginia Auditor of Public Accounts, which includes a review of the waiver, to ensure compliance with state and federal accounting practices. The Virginia Auditor of Public Accounts is the entity responsible for conducting the periodic independent audit of the waiver program under the provisions of Single Audit Act. DMAS is also subject to audits from CMS through the medical integrity audits.

Whatever the FFP was at the time of the original payment is the rate used to calculate the FFP (federal share). CMS requires states to return the federal share of any overpayment within 360 days/year of discovery. DMAS has elected to return the federal share of any overpayments at one year from discovery, regardless if we have collected the outstanding balance or not for compliance reasons. If nothing is collected by the one year mark, the federal share of the overpayment is returned to CMS using state funds.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA1. Number and percent of adjudicated waiver claims that were submitted and

reimbursed using the correct rate in accordance with the approved DMAS rate schedule. N: Number of adjudicated waiver claims that were submitted and reimbursed using the correct rate in accordance with the approved DMAS rate schedule. D: Total number of adjudicated claims

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☑ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☑ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FA3. Number and percent of paid claims that have supporting documentation that the service was rendered N: Number of paid claims that have supporting documentation that the service was rendered D: Number of claims reviewed

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☑ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =* *95% confidence lvl & +/- 5% margin of error*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA4. Number and percent of claims adhering to the approved rate/rate methodology in the waiver application. N: number of claims adhering to the approved rate/rate methodology in the waiver application. D: Total number of claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =* *95%*
☐ ***Other*** *Specify:*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

If DMAS staff identifies problems with the above measure for providers, they require a corrective action plan to be developed and implemented by the provider. Failure to do so jeopardizes the Medicaid provider agreement.

If claims have been paid inappropriately, referral is made to DMAS Program integrity Division for collection and overpayment.

Individual providers with systemic problems will be targeted for technical assistance/training from DMAS. These events and their results will be documented in quarterly reports of technical assistance.

The provider has four opportunities to provide input to the audit: Request for Reconsideration, Request for an Information Fact Finding Conference (IFFC), Formal Evidential Hearing, and Circuit Court. All are dictated by State regulations and handled by the Department's Appeals Division. To address the education letter upon receipt, the provider has thirty days to submit additional documentation or information to explain their understanding of the regulations and policy. An exit conference is held telephonically with provider. Preliminary report is revised if applicable and then the final report is written. A total of 99 referrals were made in the last fiscal year. This includes both provider and recipient referrals. DMAS does not perform on-site, unannounced visits for payment review. DMAS QMR staff reviews claims submitted by selected providers based on a statistically valid sample of 95/5 confidence level.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ ***No***
- ○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Rate determination and oversight is a shared responsibility between the Department of Medical Assistance Services (DMAS) and the Department of Behavioral Health and Developmental Services (DBHDS). The DMAS Provider Reimbursement Division ensures that rates are based on the approved methodologies; are in accordance with authorized funding; and consistent with economy, efficiency, and quality of care' and are sufficient to attract a sufficient number of providers. DMAS conducts a review of existing rates at least every five (5) years to ensure rates remain sufficient to attract qualified providers. A complete listing of all current Developmental Disability (DD) waiver services rates is maintained on the DMAS Web site (https://www.dmas.virginia.gov/for-providers/long-term-care/waivers/) and is available to the public for review. Individuals may call DMAS at 1-804-786-6145 to request a written copy of the rate schedule.

Services are reimbursed on a prospective, fee-for-service basis, with the exceptions discussed below. Rates vary by region with higher rates paid for services in Northern Virginia to account for higher wage and other costs compared to the rest of the Commonwealth. All providers - including public providers - are paid the same rates for waiver services. There is no rate reconciliation methodology for public providers or Medicaid cost report for these services. In general, rates are adequate to attract a sufficient number of providers to furnish services to individuals.

DBHDS engaged Health Management Associates (HMA), formerly Burns & Associates, Inc. (B&A), a national consultant experienced in developing provider reimbursement rates for home and community based services, to conduct a rate study. The rate study process began in 2014 and the same process was used to update the rates in 2021. The rate study encompassed several activities, including varied opportunities for public comment.

The rate study included several strategies to ensure compliance with the statutory provision of § 1902(a)(30)(A). This included a provider survey that captured cost data and operational details (e.g., staffing levels). Each survey was reviewed for reasonableness and statistical calculations were performed to identify statistical outliers. In addition to findings from the survey, the rate models rely on a variety of published data sources (such as wage data from the Bureau of Labor Statistics, health insurance cost data from the Medical Expenditure Panel Survey, the Internal Revenue Service's standard mileage rate, etc.) to ensure that cost modeling reflects actual market-based costs. Claims data was analyzed to evaluate service levels, provider counts, and other utilization measures. Further, the rates were vetted through multiple public processes (a comment period as part of the rate study, legislative review, and public comments as part of the waiver reauthorization process).

- *DBHDS identified policy goals that could be affected by the rates. These goals included providing adequate funding for direct support professionals' wages, benefits, and training to reduce turnover and professionalize the workforce; moving away from one-size-fits-all rates to better support members across the continuum of needs, including those transitioning from institutional settings; and encouraging individualized and person-centered supports, consistent with the home and community based services rule.*
- *A rate-setting advisory group comprised of providers was convened several times during the rate-setting process to serve as a 'sounding board' to discuss project goals and materials.*
- *All providers were invited to complete a survey related to their service design and costs. A more recent survey was administered in 2021 in order to finalize those rate models.*
- *Benchmark data was identified and researched, including the Bureau of Labor Statistics' cross-industry wage and benefit data as well as rates for comparable services in other waiver programs.*
- *Proposed rate models that outline the specific assumptions related to each category of costs were developed.*
- *Analysis was conducted to use Supports Intensity Scale® (SIS®) assessment data to create 'tiered' rates for residential and day habilitation services to recognize the need for more intensive staffing for individuals with more significant needs. Specifically, each member is assigned to one of six or seven levels based on assessment results in the areas of home living support needs, community living support needs, lifelong learning, work, health and safety needs, social needs, advocacy needs, medically-related support needs, and behaviorally-related support needs. These support levels, in turn, are cross-walked to four reimbursement tiers.*
- *The proposed rate models and supporting documentation were posted on a dedicated website. Providers and other stakeholders were notified of the posting via email. A webinar was conducted and recorded to explain the proposals. A dedicated email address was created to accept comments and suggestions for a period of approximately one month. DBHDS reviewed every comment submitted and prepared a written document summarizing its response to each, including any resulting revision to the rate models or an explanation for why no change was made. This non-required comment period occurred before the proposed rates were formally incorporated into the waiver application. The entire application, including the rates, was then subject to a formal comment period overseen by DMAS.*

Based on the rate study, HMA developed independent rate models intended to reflect the costs that providers face in delivering a given service. Specific assumptions are made for these various costs, including:

- *The wage of the direct support professional*
- *Benefits for the direct support professional*
- *The productivity of the direct support professional (to account for non-billable responsibilities)*
- *Other direct care costs, such as transportation and program supplies*
- *Agency overhead costs*
- *Programmatic factors that impact per-person costs, such as staffing ratios*

Specific cost assumptions were based on provider-reported data as well as other benchmarks. Wage and benefit assumptions were derived primarily from BLS data to ensure waiver providers' competitiveness. Assumptions related to agency overhead costs are based primarily on cost data from private (non-public) providers. Specifically, overhead is divided into administrative and program support. Administrative costs are those associated with the operation of an organization, but which are not program-specific, including general management, financial/accounting, and human resource staff. Program support costs are expenses that are neither direct care nor administrative. Such activities are program-specific, but not on behalf of an individual member, such as training of direct care workers, program development, supervision, and quality assurance. The rate models assume that 11 percent of the total rates support agency administrative costs. Another 10 percent (on average) of the total rate is assumed to cover program support costs.

The rate setting methodology described above was used to establish benchmark rates for the following services:

- *Shared living*
- *Supported living*
- *In-Home Support*
- *Sponsored residential*
- *Group home residential*
- *Skilled and Private Duty Nursing*
- *Therapeutic Consultation*
- *Crisis Supports (crisis support services, community-based crisis supports, center-based crisis supports)*
- *Group supported employment*
- *Community engagement*
- *Group day services*
- *Workplace assistance services*
- *Personal assistance (agency and consumer direction)*
- *Respite Care (agency and consumer direction)*
- *Companion Care (agency and consumer direction)*
- *Service Facilitation*
- *Benefits Planning Services (added for amendment effective 7/1/18)*

The rate model assumptions are used to construct the fee-for-services rates, but the individual assumptions are not prescriptive to service providers. For instance, providers are not required to pay the wages assumed in the rate models. Rather, providers have the flexibility within the total rate to design programs that meet members' needs, consistent with service requirements and members' individual support plans.
While there is no formal schedule for annual cost of living increases to the rates, the use of detailed and transparent rate models allows for periodic review and adjustment of the rates. Rates are not increased automatically for inflation but may be increased if authorized by the state budget through the VA General Assembly. Rate increases are subject to funding by the General Assembly as part of the state budgeting process. Recommendations for rate adjustments as part of budget deliberations may come from DMAS and DBHDS or service recipients, providers, and other members of the public.

Most of the rate models have been fully funded, but for certain services a lesser 'adopted' rate has been implemented:

- *Skilled Nursing rates for registered nurses are funded at 80 percent of the rate model for Northern Virginia and 80 percent for the rest of the state.*
- *Skilled Nursing rates for licensed practical nurses are funded at 80 percent of the rate model for Northern Virginia and 80 percent for the rest of the state.*
- *Private Duty Nursing rates for registered nurses are funded at 80 percent of the rate model for Northern Virginia and 80 percent for the rest of the state.*

• Private Duty Nursing rates for licensed practical nurses are funded at 80 percent of the rate model for Northern Virginia and 80 percent for the rest of the state.
• Agency rates for Personal Assistance, Respite, and Companion Care are funded at 68 percent of the rate model for Northern Virginia and 62 percent for the rest of the state.
• Consumer-directed rates for Personal Assistance, Respite, and Companion Care are funded at 75 percent of the rate model for Northern Virginia and 82 percent for the rest of the state. Effective 7/1/2021, consumer-directed attendants working an average of 20 hours per week or at least 90 hours per month shall be eligible to earn paid sick leave.
• Across all consumer-directed services facilitation supports, rates are funded at an average of 85 percent of the rate model for Northern Virginia and 73 percent for the rest of the state.

Continued in Main Optional B with the process of public input on rate methodology, Customized Rate Methodology, and services not included in the rate study.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Provider billings flow directly to the State's claims payment system, with the exception of those provider billings for consumer-directed services and those services (Assistive Technology, Environmental Modifications and Transition Services) for which the CSBs is not the service provider and acts as a conduit between DMAS and non-provider agencies in the community. Providers submit claims on the CMS-1500 to the private contractor, the fiscal agent for DMAS. The contractor reviews the claims and determines whether it should be paid, denied or pended. If it is denied, the provider is notified and the reason is explained. If a claim is pended, DMAS is responsible for reviewing and making a determination to either pay or deny.

Consumer-directed services are paid through a contract with a fiscal management services agent. DMAS procures fiscal agent services through an RFP process and contracts with the vendor for all payroll functions. Time sheets for consumer-directed personal assistants, respite assistants and companions are submitted directly to the FMS by the individual/employer after authorization and approval of the employer. The fiscal management service contractor submits payment to the employee attendant for authorized services. DMAS provides direct oversight of the contract to ensure compliance with federal and state law. DMAS contract monitors on a weekly basis sample approved assistant applications to ensure all qualifications are met. Payments are made only to those assistants that have approved assistant applications.

The CSB may enter into a contractual arrangement with non-providers such as building contractors, stores that may provide AT items or even on-line vendors. After making the purchase, the CSB then bills DMAS for the modification/item. Those vendors (such as DME companies or others) who wish to become DMAS enrolled providers may do so. There is no requirement that billing for these services flow through the CSBs. It is merely one option.

On a quarterly basis, the contractor obtains payroll information for CD attendants to determine if payroll information was properly supported by testing a judgmental sample of the entries from the payroll register and other state and federal tax forms.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

DMAS ensures that, when claims are paid, the individual is Medicaid-eligible at the time the services were rendered and the services being billed are approved services in the service plan for that individual. When submitting a claim, the provider enters all elements from the CMS-1500. As noted in section I-1, all services must be pre-authorized by DBHDS. Secondly, prior to payment, all claims are processed using automated edits that:

1. Verify individual eligibility;
2. Check for a valid pre-authorization;
3. Verify there is no duplicate billing;
4. Verify that the provider submitting claims meets provider participation criteria and has a valid participation agreement with DMAS;
5. Check for any service limits.

Quality Management Review (QMR) ensures that services are approved and appropriate for the individual. The purpose of the QMR is to determine whether services delivered were appropriate, continue to be needed by the individual, and the amount and kind of services were required. DMAS analysts conduct QMR of all documentation that shows the individual's level of care. Visits are conducted on-site and are unannounced. DMAS QMR staff reviews claims submitted by selected providers based on a statistically valid sample of 95/5 confidence level.

The QMR visit is accomplished through a review of the individual's record, evaluation of the individual's medical and functional status, and consultation with the individual and family/caregiver, as appropriate. Specific attention is paid to all applicable documentation, which may include service plans, supervisory notes, services facilitator notes, daily logs, self-directed employee time sheets, progress notes, case manager notes and any other documentation.

The amended waivers will all utilize a web-based, electronic submission service authorization process. Providers relay their information (such as plans for support) to the case manager who then ensures that all requests meet the individual's needs and are in line with the discussions during the person-centered planning meeting. The case manager submits required documentation via the electronic system to DBHDS service authorization staff. These staff ensure that all services being requested are justified by assessed needs, service limits are observed, and that the individual requires the services being requested. Once these have been confirmed, the staff will authorize: notification goes back to the case manager and provider and entry into VAMMIS is accomplished. If required elements are missing, the request may be pended for more information, rejected or denied (depending on the circumstances).

Individuals seeking case management services through the Community Services Board Single Point of Entry are offered a choice of case manager.
Choice of providers is always an option and can be exercised at any time by individuals once they have a Waiver slot. The CSB/BHA support coordinator/ case manager is responsible for reviewing with the individual and authorized representative (AR), as appropriate, the list of available providers and documenting choice of providers on the Virginia Informed Choice form 1) at initiation of Waiver services 2) whenever requested thereafter for any reason by the individual and AR, as appropriate 3) if the support coordinator/ case manager has a documented reason to believe that the individual may benefit from offering choice of providers (e.g., if the support coordinator/ case manager, in consultation with the individual and AR, as appropriate, determines that the individual's person-centered plan outcomes are consistently not being achieved); or 4) if the individual and AR, as appropriate, expresses dissatisfaction with current services. Choice of providers is offered whenever a new service is offered. The annual Person-Centered Planning meeting includes a discussion of services options and satisfaction with supports and services received.

The Individual Choice form documents choice of waiver vs. institution and is completed following initial waiver eligibility screening, as well as annually while the individual is on the statewide waiting list.

For PTs and OTs, The evaluations may be directly reimbursed through the State Plan or through Therapeutic Consultation, if the individual is already receiving those services. CRSs/Rehab Engineers may be reimbursed directly through either EM or AT if their services are required.

EVV is part of the pre-payment review for personal care, respite, and companion services. Claims must include all EVV-required elements in order to be paid. Edits are in the MMIS and encounter systems to ensure claims are not paid without the EVV data. Exceptions to EVV requirements are made for live-in providers and residential respite providers.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims*

(including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ● ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Consumer-directed payroll for personal assistance, respite and companion services are paid through the Fiscal Management Services (FMS) contractor. The individual/employer directly submits authorized employee time sheets to FMS contractor, which processes the billing and makes payment directly to the individual's employee. The claim information is still captured in the VAMMIS system to satisfy reporting requirements to CMS and are subject to all audit and accounting oversight measures.

Self-directed personal assistance, respite, and companion service providers are not able to receive direct payment from DMAS. There is no option for consumer-directed providers to bill DMAS.

The administrative activity is a per member per month fee and includes the contractor's direct and indirect costs. Direct costs include staffing, project supplies and materials, facilities, software, equipment, telecommunications, postage, printing, and subcontracts. Indirect costs include administrative staffing and services, general purpose equipment, facilities, telecommunications and general use office supplies.

DMAS employs contract monitoring staff within the Division of Long-Term Care to provide ongoing oversight for the administration of the contract for fiscal management services. The vendor provides a bi-weekly payroll register documenting the individual payments associated with eligible waiver individuals for each service provided to the individual by qualified assistant(s) for the pay period. DMAS staff authorize each voucher for payment through DMAS's Fiscal and Purchases Division for generation of payment through the Virginia Department of Accounts. The payroll process is subject to random audit through the various oversight entities, including the auditor of public accounts (Virginia Department of Accounts) and the DMAS Division of Internal Audit.

In addition, DMAS staff provide quarterly reports to the Budget and Contract Management Division within DMAS to ensure that the vendor complies with the requirements of the contract, including fiscal accountability.

- ○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☑ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☑ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

DMAS contracts with a Fiscal Management Service (FMS), to make payment for all consumer-directed services. The fiscal employer agent ensures that attendants have completed required employment paperwork; processes individual/employer enrollment packets and attendant employment packets; obtains criminal record checks and child abuse background checks; processes time sheets, deducts and files state and federal income and employment taxes and pays consumer-directed employees. Oversight of the FMS operations is conducted by contract monitors employed by the Medicaid agency.

There is no option for self-directed providers to bill Medicaid directly.

DMAS employs contract monitoring staff within the Office of Community Living to provide ongoing oversight for the administration of the contract for fiscal management services. The FMS vendor provides weekly estimated and reconciled payroll registers, documenting the individual payments associated with eligible waiver individuals for each service provided to the individual by qualified assistant(s) for the pay period. DMAS staff authorizes each voucher for payment through DMAS' Fiscal and Purchases Division for generation of payment through the Virginia Department of Accounts. The payroll process is subject to random audit through the various oversight entities, including the auditor of public accounts (Virginia Department of Accounts) and the DMAS Division of Internal Audit. Data from the operation meetings are used to develop the annual performance audit.
In addition, the FMS provides the DMAS fiscal office with quarterly, tax accrual reconciliation reports, annual FICA refund voucher reports, and annual unclaimed property reports for checks that have not been cashed. The FMS also provides monthly reports to DMAS Provider Reimbursement (rate setting) staff and weekly financial operations reports to DMAS contract monitors.

The FMS provides the following program reports to DMAS contract monitors: weekly operations reports that reflect employer and employee enrollment, background checks, discontinued employment, and timesheet processing; weekly Call Center activity reports; and quarterly program activity reports. DMAS contract monitors provide on-site weekly monitoring of the FMS and hold bi-weekly operations meetings with management, fiscal, IT, Call Center, and operations staff. DMAS contract monitors complete an annual performance audit of the FMS, develop corrective action plans, when necessary, and provide twice yearly reports to the DMAS Contract Management Division ensure contract compliance, including fiscal accountability.

In addition to the on-going monitoring conducted by the DMAS employed contract monitors, DMAS contracts with an independent auditor to conduct quarterly post payment reviews of the consumer directed payroll. The auditor conducts analysis of the F/EA payroll register showing employer, employee, pay rates, hours worked, gross pay, state and federal taxes, unemployment insurance and other withholdings. The independent auditor has the expertise and resources necessary to accurately and efficiently review large payroll registers and supporting tax and payroll bank account information ensuring fiscal controls.
For Environmental Modifications/Assistive Technology, when the CSB is not the provider, the CSBs may act as a conduit between the service provider and DMAS. They may be involved in purchasing items for Assistive Technology directly (from stores or online providers - particularly for items such as communication devices, computer programs, I-pads, etc. that regular DME companies do not deal with) or may work with a building contractor to perform some Environmental Modification for which the CSB bills DMAS and then reimburses the contractor. It is not advantageous to building contractors to become Medicaid waiver providers in general. Provider Integrity audits the CSBs in these instances, as they are the provider-of-record for the service. At this time the CSBs do not receive payments for processing payments. Some CSBs have contracts with certain vendors. Some CSBs require three bids.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

CSBs are eligible to be providers of waiver services for which they meet provider criteria. Some choose to be waiver providers and others do not. Their provision of waiver services depends on historical factors and the guidance of their local governance. Some provide only case management and emergency services (required by state statute). Others also provide some combination of services that may include any of the following: group home residential, sponsored residential, in-home support services, respite, group day services, individual supported employment, group supported employment, center-based crisis supports, community-based crisis supports, crisis support services, assistive technology, environmental modifications, therapeutic consultation, personal assistance, or companion services.

CSBs are established by local governments pursuant to section 37.2-500 or 37.2-601 of the Code of Virginia and are under the control of local elected officials (city council and board of supervisors members who establish the CSB, approve its annual "performance contract" with DBHDS and appoint CSB board members).

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select

one:

- ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment *(6 of 7)*

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) In Virginia, CSBs are OHCDS entities for the waiver services of assistive technology, environmental modifications and transition services. CSBs are all licensed by DBHDS to provide at least one other waiver or State Plan service.

(b) Providers of these three waiver services have the option to directly enroll as a DMAS provider should they not desire to work through the CSB.

(c) Individuals have the right to choose their provider of services despite the OHCDS arrangement and frequently tell the CSB staff whom they would like to provide the device, complete their home modification, etc. QMR staff inquire about whether this choice took place when they meet with individuals and family/caregivers.

(d) While those agencies or individuals who provide these three services may not actually enter into a contractual arrangement with the CSB through which they are paid (as these services generally represent short-term or single purchase transactions), those who provide goods and services through an OHCDS arrangement must still meet all DD waiver requirements. Furthermore, the CSB case manager is required to document the successful delivery or completion of the item/modification/service once completed.

(e) & (f) An independent professional consultation shall be obtained from staff knowledgeable of that item (e.g., Physical Therapist, Occupational Therapist, Speech and Language Therapist, etc.) for each AT request prior to service authorization. All AT items to be covered shall meet applicable standards of manufacture, design, and installation. 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.

A physical therapist or occupational therapist may be utilized to evaluate the needs for environmental modifications and make recommendations about what is required, when appropriate. Alternately, a rehabilitation engineer or Certified Rehabilitation Specialist may be used in cases where structural modifications of the primary residence are requested to evaluate the individual's needs and subsequently act as project manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. The rehabilitation engineer may actually design and personally complete the modification.

A rehabilitation engineer/CRS may be required if (for example):
- *The environmental modification involves combinations of systems which are not designed to go together.*
- *The structural modification requires a project manager to assure that the design and functionality meet ADA accessibility guidelines.*
- *Where structural modifications of the primary residence are requested to ensure the residence is structurally sound for the modifications.*

The case manager must document notification by the individual or individual's representative of satisfactory completion or receipt of the service or item of Assistive Technology. For Environmental Modifications the case manager must, upon completion of each modification, meet face-to-face with the individual and the family/caregiver, as appropriate, to ensure that the modification was completed satisfactorily and is able to be used by the individual.

All three services must be preauthorized and are thus scrutinized for need for service, appropriate professional recommendation (particularly Assistive Technology), cost effectiveness, and remaining within the monetary limits for the service. DMAS QMR staff further review these elements during their service reviews. DMAS Provider Integrity Audits ensure that services performed under these contracts meet applicable requirements and meet financial accountability standards.

For PTs and OTs, The evaluations may be directly reimbursed through the State Plan or through Therapeutic Consultation, if the individual is already receiving those services. CRSs/Rehab Engineers may be reimbursed directly through either EM or AT if their services are required.

Part of the service authorization process for EM/AT is the review (by DBHDS staff who perform service

authorization) of documentation by the appropriate professional that the particular item or modification is necessary for the individual. Without this information accompanying the service authorization request, the request will not move forward. In addition, the service authorization staff ensure that all service limits (including monetary limits for EM/AT) are observed before authorization is finalized.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- [x] ***Appropriation of State Tax Revenues to the State Medicaid Agency***
- [ ] ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the

Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes*

or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The amount of waiver services an individual is authorized to receive is based on documentation that demonstrates the adequacy and appropriateness of the services with regard to the individual's current functioning, cognitive status, health, safety and social needs. The Department of Medical Assistance Services pays providers an established rate to cover the costs of providing waiver services to the individual. Rates do not cover the costs of individuals' room and board. Providers are only permitted to bill for allowable activities described for each waiver service.

Generally, the fees collected from federal benefits (SSI, SSA, SSDI, Railroad Retirement, etc.) cover the costs of room and board for residential services. If not, providers use other sources of revenue to cover the remainder. Other revenue sources that are used include, but are not limited to:

** private pay fees;*
** fees from consulting, training, and other contractual services;*
** charitable sources (endowments, organization or private foundations, United Way, fundraising efforts);*
** HUD 811 and Section 8 programs; or*
** State General Fund and local funding.*

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ( ) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- (●) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs***

attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

*a) The state will make an individual-by-individual determination of the actual costs of room and board apportioned to the live-in companion up to the average Department of Housing and Urban Development (HUD) Fair Market Rent (FMR) amount in the highest rent region in "Rest of State" (ROS) and in Northern Virginia (NOVA). Room and board payments to the live-in companion will include the reimbursable monthly cost of rent/mortgage, food, and internet service.**

- *The room and board expenses for the live-in companion are determined to be equal, on the average, to one-half of the lesser of the HUD FMR amount of room and board paid by the individual receiving services.*
- *The reimbursement would incorporate statewide estimates to project costs. The reimbursement formula would include ½ the amount of monthly rent, food, and internet service, with a flat 11% administrative overhead fee provided to the provider agency. The rental reimbursement range will incorporate a maximum amount (cap) for both geographic regions ROS and NOVA.*
- *The assistance being received by the individual from any federal benefit programs will be deducted to offset the rent amount paid by the waiver.*
- *The state has determined that the amount of any benefits the individual may be eligible to receive (i.e., SNAP) will be deducted from the household costs for rent, food and utilities prior to calculating costs associated with the live-in companion.*
- *If the lease is a related party transaction, total payment for the portion of rent attributable to the live-in companion is further limited to the landlord's actual cost of ownership.*
- *If the individual owns their own home and is making mortgage payments, the annual interest paid on the mortgage will be included in the rental amount.*

** NOTE: Research by our subcontractor, HMA, indicated that the HUD FMR rent amounts include utility costs, so separate assumptions were removed. Internet is not included in the FMR so that assumption was built into the model.*

b) The licensed coordinating agency will bill DMAS for the live-in companion's rent and food expenses and then transmit that to the individual for paying the expenses.

The enrolled provider agency will bill DMAS monthly for the live-in companion's rent and food expenses and will reimburse the waiver participant monthly for these expenses.

NOTE: Research by our subcontractor, HMA, indicated that the HUD FMR rent amounts include utility costs, so separate assumptions were removed. Internet is not included in the FMR so that assumption was built into the model.

Documentation (e.g., copy of the actual lease/mortgage payment statement) must be submitted to service authorization staff with the request for authorization of Shared Living.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	124184.04	18536.00	142720.04	255751.00	10033.00	265784.00	123063.96
2	122517.00	19704.00	142221.00	260099.00	10665.00	270764.00	128543.00
3	122919.21	20945.00	143864.21	264521.00	11337.00	275858.00	131993.79
4	122182.22	22265.00	144447.22	269018.00	12052.00	281070.00	136622.78
5	122206.84	23668.00	145874.84	273591.00	12811.00	286402.00	140527.16

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	12558		12558
Year 2	12733		12733
Year 3	12733		12733
Year 4	12733		12733
Year 5	12733		12733

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The projected length of stay on the waiver is based on the actual average length of stay reported on the CMS-372 from SFY 2022. The average length of stay is 352 days. The length of stay does not vary much year to year. The State has traditionally used the LOS from the prior year when calculating the projected LOS. This is the methodology that the State has previously understood that CMS has recommended.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

In December of 2023, DMAS reviewed the previous 3 years reported CMS 372 reports (FY20 -FY22) plus a preliminary FY23 report to capture service users, units per user per year and average cost per unit for each waiver service. The baseline year of Fiscal Year 2025 (July 2024 to June 2025) was projected using the values from the preliminary FY23 report with some changes. Additional waiver slots were approved, 100 in July 2023 and 70 more in January 2024. A proportional number of additional users were assumed in each service. Also, a rate increase for personal care attendants was approved to begin January of 2024 and so the cost per unit was adjusted for agency-directed and consumer-directed personal assistance services, respite care and companion care. DMAS has no reason to believe that the units per user will change. No policies are in place to change utilization and the utilization changes from the COVID public health emergency are assumed to be over. Rate changes only happen when directed by state legislative action, and current state budgets have no additional rate changes at this point. As noted below, some utilization and cost per units have historical values that have been adjusted to either have some expected utilization or a cost per unit that falls within approved rates. Any growth in users is based directly on the estimated change in unique members, with rounding.

Some services had average costs per unit below the lowest rate for those services after recent rate increases. The rates for non-professional and professional center-based crisis supports and professional crisis supports are expected to be the average of the rate schedule. Other services had little to no history of utilization. DMAS has estimated a small amount of utilization for non-professional crisis supports, public transportation, peer mentoring, personal emergency response system (PERS) and shared living above their historical levels.

Unique member utilizing service lags slightly behind available slots. The gap is expected to narrow by 75% each year until the unique members utilizing the services matches the waiver slots in waiver year 5. No additional slots are included as they have not been approved.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is based on the FY23 preliminary CMS-372 report of non-waiver services costs ($16,403 per person per year) with a growth rate of 6.3% which is the average growth rate from FY20 to FY23 for factor D'. DMAS calculated the growth rate based on FY20 and FY21 data from the CMS-372 reports and preliminary CMS-372 reports for FY22 and FY23.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is based on the FY23 preliminary report on facility care costs ($247,231 per person per year) with a growth rate of 1.70% which is the average growth rate from FY20 to FY23 for Factor G. DMAS calculated the growth rate based on FY20 and FY21 data from the CMS-372 reports and preliminary CMS-372 reports for FY22 and FY23. The source is the preliminary CMS-372 report for FY23. Preliminary reports do not quite have the claims run-out that actual 372 reports eventually have.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these*

estimates is as follows:

Factor G' is based on the FY23 preliminary CMS-372 report on facility care costs of non-facility costs ($8,879 per person per year) with a growth rate of 6.3% based on the factor D' growth rate. DMAS calculated the growth rate based on FY20 and FY21 data from the CMS-372 reports and preliminary CMS-372 reports for FY22 and FY23. The volatility of high growth in factor G' in those reports was not expected to continue and so the factor for D' was used instead as a proxy for growth in acute care for individuals with the same level of care. Preliminary reports do not quite have the claims run-out that actual 372 reports eventually have. The source is the preliminary CMS-372 report for FY23.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Group Day Services	
Group Home Residential	
Individual Supported Employment	
Personal Assistance Services	
Respite	
Consumer-Directed Services Facilitation (until 5/31/27)	
Assistive Technology	
Benefits Planning	
Center-based Crisis Supports	
Community Coaching	
Community Engagement	
Community Guide	
Community-Based Crisis Supports	
Companion Services	
Crisis Support Services	
Electronic Home-Based Services	
Employment and community transportation	
Environmental Modifications	
Group Supported Employment	
In-home Support Services	
Peer Mentor Supports	
Personal Emergency Response System	
Private Duty Nursing	
Shared Living	
Skilled Nursing	
Sponsored Residential	
Supported Living	
Therapeutic Consultation	
Transition Services	
Workplace Assistance Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Day Services Total:						113603235.02
Group Day Services	hour	5515	1032.00	19.80	112691304.00	
Group Day Services - Customized Rate	hour	22	1001.00	41.41	911931.02	
Group Home Residential Total:						746102855.76
Group Home Residential Customized Rate	day	159	216.00	781.83	26851169.52	
Group Home Residential	day	5672	309.00	410.38	719251686.24	
Individual Supported Employment Total:						5816886.60
Individual Supported Employment	hour	514	170.00	66.57	5816886.60	
Personal Assistance Services Total:						158373488.47
Consumer-Directed Personal Assistance Services	hour	2689	3035.00	16.29	132944563.35	
Personal Assistance Services	hour	424	2774.00	21.62	25428925.12	
Respite Total:						8204340.96
Respite Care	hour	283	220.00	21.24	1322402.40	
Consumer-Directed Respite Care	hour	1312	322.00	16.29	6881938.56	
Consumer-Directed Services Facilitation (until 5/31/27) Total:						1750001.20
Consumer-Directed Services Facilitation	visit	2689	10.00	65.08	1750001.20	

GRAND TOTAL: 1559503193.35

Total Estimated Unduplicated Participants: 12558

Factor D (Divide total by number of participants): 124184.04

Average Length of Stay on the Waiver: 350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(until 5/31/27)						
Assistive Technology Total:						650810.28
Assistive Technology	service	274	2.00	1187.61	650810.28	
Benefits Planning Total:						20532.96
Benefits Planning	hour	42	8.00	61.11	20532.96	
Center-based Crisis Supports Total:						3028914.24
crisis Non-Professional	hour	61	181.00	29.04	320630.64	
crisis Professional	hour	85	298.00	106.92	2708283.60	
Community Coaching Total:						6104315.23
Community Coaching	hour	270	542.00	41.58	6084817.20	
Community Coaching Customized Rate	hour	1	277.00	70.39	19498.03	
Community Engagement Total:						30252563.55
Community Engagement	hour	2277	467.00	28.45	30252563.55	
Community Guide Total:						132917.40
Community Guide	hour	21	105.00	60.28	132917.40	
Community-Based Crisis Supports Total:						178939.20
crisis non-professional	hour	5	10.00	29.04	1452.00	
crisis professional	hour	166	10.00	106.92	177487.20	
Companion Services Total:						18786540.00
Companion Services	hour	239	1200.00	22.31	6398508.00	
Consumer-Directed Companion Services	hour	600	1284.00	16.08	12388032.00	
Crisis Support Services Total:						1151592.32
crisis non-professional	hour	32	470.00	31.06	467142.40	
crisis					684449.92	

GRAND TOTAL: 1559503193.35

Total Estimated Unduplicated Participants: 12558

Factor D (Divide total by number of participants): 124184.04

Average Length of Stay on the Waiver: 350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
professional	hour	32	187.00	114.38		
Electronic Home-Based Services Total:						190508.49
Electronic Home-Based Services	service	61	3.00	1041.03	190508.49	
Employment and community transportation Total:						32443.22
Public transportation	trip	5	6.00	2.42	72.60	
Trips 10-20 miles	trip	5	890.00	1.57	6986.50	
Trips under 10 miles	trip	8	733.00	1.79	10496.56	
Trips 20+ miles	trip	6	2558.00	0.97	14887.56	
Environmental Modifications Total:						189212.52
Environmental Modifications	service	49	1.00	3861.48	189212.52	
Group Supported Employment Total:						4093822.08
Group Supported Employment	hour	288	703.00	20.22	4093822.08	
In-home Support Services Total:						87631045.54
In Home Support Services Customized Rate	hour	2	4640.00	58.27	540745.60	
In Home Support Services	hour	1173	1918.00	38.71	87090299.94	
Peer Mentor Supports Total:						2323.70
Peer Mentor Supports	hour	5	19.00	24.46	2323.70	
Personal Emergency Response System Total:						971.40
Personal Emergency Response System	service	5	6.00	32.38	971.40	
Private Duty Nursing Total:						57782835.54
Private Duty Nursing	15 min	337	11982.00	14.31	57782835.54	
Shared Living Total:						2550.00

GRAND TOTAL: 1559503193.35

Total Estimated Unduplicated Participants: 12558

Factor D (Divide total by number of participants): 124184.04

Average Length of Stay on the Waiver: 350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Shared Living	month	1	3.00	850.00	2550.00	
Skilled Nursing Total:						2083612.30
Skilled Nursing	15 min	203	602.00	17.05	2083612.30	
Sponsored Residential Total:						282048957.00
Sponsored Residential	day	2610	308.00	350.63	281864444.40	
Sponsored Residential Customized Rate	day	2	235.00	392.58	184512.60	
Supported Living Total:						14043540.00
Supported Living	day	140	290.00	345.90	14043540.00	
Therapeutic Consultation Total:						16186436.82
Therapeutic Consultation	hour	1857	57.00	118.24	12515585.76	
Therapeutic Consultation Other Provider	hour	909	46.00	87.79	3670851.06	
Transition Services Total:						500.00
Transition Services	item	1	1.00	500.00	500.00	
Workplace Assistance Services Total:						1056501.55
Workplace Assistance Services	hour	65	391.00	41.57	1056501.55	

GRAND TOTAL: 1559503193.35

Total Estimated Unduplicated Participants: 12558

Factor D (Divide total by number of participants): 124184.04

Average Length of Stay on the Waiver: 350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Day Services Total:						115544427.02
Group Day Services	hour	5610	1032.00	19.80	114632496.00	
Group Day Services - Customized Rate	hour	22	1001.00	41.41	911931.02	
Group Home Residential Total:						759036608.76
Group Home Residential Customized Rate	day	162	216.00	781.83	27357795.36	
Group Home Residential	day	5770	309.00	410.38	731678813.40	
Individual Supported Employment Total:						5918738.70
Individual Supported Employment	hour	523	170.00	66.57	5918738.70	
Personal Assistance Services Total:						134715952.58
Consumer-Directed Personal Assistance Services	hour	2202	3035.00	16.29	108867210.30	
Personal Assistance Services	hour	431	2774.00	21.62	25848742.28	
Respite Total:						8348348.70
Respite Care	hour	288	220.00	21.24	1345766.40	
Consumer-Directed Respite Care	hour	1335	322.00	16.29	7002582.30	
Consumer-Directed Services Facilitation (until 5/31/27) Total:						1779938.00
Consumer-Directed Services Facilitation (until 5/31/27)	visit	2735	10.00	65.08	1779938.00	
Assistive Technology Total:						662686.38
Assistive Technology	service	279	2.00	1187.61	662686.38	
Benefits Planning Total:						21021.84
Benefits Planning	hour	43	8.00	61.11	21021.84	
Center-based Crisis						3066032.64

GRAND TOTAL: 1560008905.35

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122517.00

Average Length of Stay on the Waiver: 350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports Total:						
crisis Non-Professional	hour	62	181.00	29.04	325886.88	
crisis Professional	hour	86	298.00	106.92	2740145.76	
Community Coaching Total:						6216997.03
Community Coaching	hour	275	542.00	41.58	6197499.00	
Community Coaching Customized Rate	hour	1	277.00	70.39	19498.03	
Community Engagement Total:						30770723.40
Community Engagement	hour	2316	467.00	28.45	30770723.40	
Community Guide Total:						132917.40
Community Guide	hour	21	105.00	60.28	132917.40	
Community-Based Crisis Supports Total:						182146.80
crisis non-professional	hour	5	10.00	29.04	1452.00	
crisis professional	hour	169	10.00	106.92	180694.80	
Companion Services Total:						19100095.20
Companion Services	hour	243	1200.00	22.31	6505596.00	
Consumer-Directed Companion Services	hour	610	1284.00	16.08	12594499.20	
Crisis Support Services Total:						1187579.58
crisis non-professional	hour	33	470.00	31.06	481740.60	
crisis professional	hour	33	187.00	114.38	705838.98	
Electronic Home-Based Services Total:						193631.58
Electronic Home-Based Services	service	62	3.00	1041.03	193631.58	
Employment and community transportation Total:						32443.22

GRAND TOTAL: 1560008905.35

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122517.00

Average Length of Stay on the Waiver: 350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Public transportation	trip	5	6.00	2.42	72.60	
Trips 10-20 miles	trip	5	890.00	1.57	6986.50	
Trips under 10 miles	trip	8	733.00	1.79	10496.56	
Trips 20+ miles	trip	6	2558.00	0.97	14887.56	
Environmental Modifications Total:						193074.00
Environmental Modifications	service	50	1.00	3861.48	193074.00	
Group Supported Employment Total:						4164895.38
Group Supported Employment	hour	293	703.00	20.22	4164895.38	
In-home Support Services Total:						89115961.14
In Home Support Services Customized Rate	hour	2	4640.00	58.27	540745.60	
In Home Support Services	hour	1193	1918.00	38.71	88575215.54	
Peer Mentor Supports Total:						2323.70
Peer Mentor Supports	hour	5	19.00	24.46	2323.70	
Personal Emergency Response System Total:						971.40
Personal Emergency Response System	service	5	6.00	32.38	971.40	
Private Duty Nursing Total:						58811610.06
Private Duty Nursing	15 min	343	11982.00	14.31	58811610.06	
Shared Living Total:						2550.00
Shared Living	month	1	3.00	850.00	2550.00	
Skilled Nursing Total:						2114404.60
Skilled Nursing	15 min	206	602.00	17.05	2114404.60	
Sponsored Residential Total:						286908688.80
Sponsored Residential	day	2655	308.00	350.63	286724176.20	

GRAND TOTAL: 1560008905.35

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122517.00

Average Length of Stay on the Waiver: 350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Sponsored Residential Customized Rate	day	2	235.00	392.58	184512.60	
Supported Living Total:						14244162.00
Supported Living	day	142	290.00	345.90	14244162.00	
Therapeutic Consultation Total:						16466720.02
Therapeutic Consultation	hour	1889	57.00	118.24	12731255.52	
Therapeutic Consultation Other Provider	hour	925	46.00	87.79	3735464.50	
Transition Services Total:						500.00
Transition Services	item	1	1.00	500.00	500.00	
Workplace Assistance Services Total:						1072755.42
Workplace Assistance Services	hour	66	391.00	41.57	1072755.42	

GRAND TOTAL: 1560008905.35
Total Estimated Unduplicated Participants: 12733
Factor D (Divide total by number of participants): 122517.00
Average Length of Stay on the Waiver: 350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Day Services Total:						116597154.52
Group Day Services	hour	5634	1037.00	19.80	115680668.40	
Group Day Services - Customized Rate	hour	22	1006.00	41.41	916486.12	
Group Home Residential Total:						767259412.03

GRAND TOTAL: 1565130253.20
Total Estimated Unduplicated Participants: 12733
Factor D (Divide total by number of participants): 122919.21
Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Home Residential Customized Rate	day	163	217.00	781.83	27654108.93	
Group Home Residential	day	5795	311.00	410.38	739605303.10	
Individual Supported Employment Total:						5976321.75
Individual Supported Employment	hour	525	171.00	66.57	5976321.75	
Personal Assistance Services Total:						125159505.47
Consumer-Directed Personal Assistance Services	hour	2211	2833.00	16.29	102036699.27	
Personal Assistance Services	hour	433	2470.00	21.62	23122806.20	
Respite Total:						8434321.92
Respite Care	hour	289	221.00	21.24	1356577.56	
Consumer-Directed Respite Care	hour	1341	324.00	16.29	7077744.36	
Consumer-Directed Services Facilitation (until 5/31/27) Total:						1787747.60
Consumer-Directed Services Facilitation (until 5/31/27)	visit	2747	10.00	65.08	1787747.60	
Assistive Technology Total:						665061.60
Assistive Technology	service	280	2.00	1187.61	665061.60	
Benefits Planning Total:						21021.84
Benefits Planning	hour	43	8.00	61.11	21021.84	
Center-based Crisis Supports Total:						3086223.36
crisis Non-Professional	hour	62	182.00	29.04	327687.36	
crisis Professional	hour	86	300.00	106.92	2758536.00	
Community Coaching Total:						6274032.02
Community Coaching	hour				6254463.60	

GRAND TOTAL: 1565130253.20

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122919.21

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		276	545.00	41.58		
Community Coaching Customized Rate	hour	1	278.00	70.39	19568.42	
Community Engagement Total:						31035934.30
Community Engagement	hour	2326	469.00	28.45	31035934.30	
Community Guide Total:						134183.28
Community Guide	hour	21	106.00	60.28	134183.28	
Community-Based Crisis Supports Total:						183216.00
crisis non-professional	hour	5	10.00	29.04	1452.00	
crisis professional	hour	170	10.00	106.92	181764.00	
Companion Services Total:						19290468.48
Companion Services	hour	244	1206.00	22.31	6565029.84	
Consumer-Directed Companion Services	hour	613	1291.00	16.08	12725438.64	
Crisis Support Services Total:						1194429.06
crisis non-professional	hour	33	473.00	31.06	484815.54	
crisis professional	hour	33	188.00	114.38	709613.52	
Electronic Home-Based Services Total:						193631.58
Electronic Home-Based Services	service	62	3.00	1041.03	193631.58	
Employment and community transportation Total:						32613.38
Public transportation	trip	5	6.00	2.42	72.60	
Trips 10-20 miles	trip	5	894.00	1.57	7017.90	
Trips under 10 miles	trip	8	737.00	1.79	10553.84	
Trips 20+ miles	trip		2572.00	0.97	14969.04	

GRAND TOTAL: 1565130253.20

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122919.21

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		6				
Environmental Modifications Total:						193074.00
Environmental Modifications	service	50	1.00	3861.48	193074.00	
Group Supported Employment Total:						4202888.76
Group Supported Employment	hour	294	707.00	20.22	4202888.76	
In-home Support Services Total:						89953732.80
In Home Support Services Customized Rate	hour	2	4664.00	58.27	543542.56	
In Home Support Services	hour	1198	1928.00	38.71	89410190.24	
Peer Mentor Supports Total:						2323.70
Peer Mentor Supports	hour	5	19.00	24.46	2323.70	
Personal Emergency Response System Total:						971.40
Personal Emergency Response System	service	5	6.00	32.38	971.40	
Private Duty Nursing Total:						59288276.16
Private Duty Nursing	15 min	344	12044.00	14.31	59288276.16	
Shared Living Total:						2550.00
Shared Living	month	1	3.00	850.00	2550.00	
Skilled Nursing Total:						2135256.75
Skilled Nursing	15 min	207	605.00	17.05	2135256.75	
Sponsored Residential Total:						289966967.56
Sponsored Residential	day	2666	310.00	350.63	289781669.80	
Sponsored Residential Customized Rate	day	2	236.00	392.58	185297.76	
Supported Living Total:						14443400.40
Supported Living	day	143	292.00	345.90	14443400.40	

GRAND TOTAL: 1565130253.20

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122919.21

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Consultation Total:						**16536790.82**
Therapeutic Consultation	hour	1897	57.00	118.24	**12785172.96**	
Therapeutic Consultation Other Provider	hour	929	46.00	87.79	**3751617.86**	
Transition Services Total:						**500.00**
Transition Services	item	1	1.00	500.00	**500.00**	
Workplace Assistance Services Total:						**1078242.66**
Workplace Assistance Services	hour	66	393.00	41.57	**1078242.66**	

GRAND TOTAL: 1565130253.20
Total Estimated Unduplicated Participants: 12733
Factor D (Divide total by number of participants): 122919.21
Average Length of Stay on the Waiver: 352

Appendix J: Cost Neutality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Day Services Total:						**116720350.12**
Group Day Services	hour	5640	1037.00	19.80	**115803864.00**	
Group Day Services - Customized Rate	hour	22	1006.00	41.41	**916486.12**	
Group Home Residential Total:						**768025181.11**
Group Home Residential Customized Rate	day	163	217.00	781.83	**27654108.93**	
Group Home Residential	day	5801	311.00	410.38	**740371072.18**	
Individual Supported						**5987705.22**

GRAND TOTAL: 1555746218.29
Total Estimated Unduplicated Participants: 12733
Factor D (Divide total by number of participants): 122182.22
Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Total:						
Individual Supported Employment	hour	526	171.00	66.57	5987705.22	
Personal Assistance Services Total:						114397287.55
Consumer-Directed Personal Assistance Services	hour	2213	2615.00	16.29	94270148.55	
Personal Assistance Services	hour	433	2150.00	21.62	20127139.00	
Respite Total:						8439599.88
Respite Care	hour	289	221.00	21.24	1356577.56	
Consumer-Directed Respite Care	hour	1342	324.00	16.29	7083022.32	
Consumer-Directed Services Facilitation (until 5/31/27) Total:						1789700.00
Consumer-Directed Services Facilitation (until 5/31/27)	visit	2750	10.00	65.08	1789700.00	
Assistive Technology Total:						665061.60
Assistive Technology	service	280	2.00	1187.61	665061.60	
Benefits Planning Total:						21021.84
Benefits Planning	hour	43	8.00	61.11	21021.84	
Center-based Crisis Supports Total:						3086223.36
crisis Non-Professional	hour	62	182.00	29.04	327687.36	
crisis Professional	hour	86	300.00	106.92	2758536.00	
Community Coaching Total:						6274032.02
Community Coaching	hour	276	545.00	41.58	6254463.60	
Community Coaching Customized Rate	hour	1	278.00	70.39	19568.42	
Community Engagement Total:						31062620.40
Community					31062620.40	

GRAND TOTAL: 1555746218.29

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122182.22

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Engagement	hour	2328	469.00	28.45		
Community Guide Total:						**134183.28**
Community Guide	hour	21	106.00	60.28	**134183.28**	
Community-Based Crisis Supports Total:						**183216.00**
crisis non-professional	hour	5	10.00	29.04	**1452.00**	
crisis professional	hour	170	10.00	106.92	**181764.00**	
Companion Services Total:						**19311227.76**
Companion Services	hour	244	1206.00	22.31	**6565029.84**	
Consumer-Directed Companion Services	hour	614	1291.00	16.08	**12746197.92**	
Crisis Support Services Total:						**1194429.06**
crisis non-professional	hour	33	473.00	31.06	**484815.54**	
crisis professional	hour	33	188.00	114.38	**709613.52**	
Electronic Home-Based Services Total:						**193631.58**
Electronic Home-Based Services	service	62	3.00	1041.03	**193631.58**	
Employment and community transportation Total:						**32613.38**
Public transportation	trip	5	6.00	2.42	**72.60**	
Trips 10-20 miles	trip	5	894.00	1.57	**7017.90**	
Trips under 10 miles	trip	8	737.00	1.79	**10553.84**	
Trips 20+ miles	trip	6	2572.00	0.97	**14969.04**	
Environmental Modifications Total:						**193074.00**
Environmental Modifications	service	50	1.00	3861.48	**193074.00**	
Group Supported Employment Total:						**4202888.76**

GRAND TOTAL: 1555746218.29

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122182.22

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Supported Employment	hour	294	707.00	20.22	4202888.76	
In-home Support Services Total:						90028365.68
In Home Support Services Customized Rate	hour	2	4664.00	58.27	543542.56	
In Home Support Services	hour	1199	1928.00	38.71	89484823.12	
Peer Mentor Supports Total:						2323.70
Peer Mentor Supports	hour	5	19.00	24.46	2323.70	
Personal Emergency Response System Total:						971.40
Personal Emergency Response System	service	5	6.00	32.38	971.40	
Private Duty Nursing Total:						59293198.80
Private Duty Nursing	15 min	344	12045.00	14.31	59293198.80	
Shared Living Total:						2550.00
Shared Living	month	1	3.00	850.00	2550.00	
Skilled Nursing Total:						2135256.75
Skilled Nursing	15 min	207	605.00	17.05	2135256.75	
Sponsored Residential Total:						290293053.46
Sponsored Residential	day	2669	310.00	350.63	290107755.70	
Sponsored Residential Customized Rate	day	2	236.00	392.58	185297.76	
Supported Living Total:						14443400.40
Supported Living	day	143	292.00	345.90	14443400.40	
Therapeutic Consultation Total:						16554308.52
Therapeutic Consultation	hour	1899	57.00	118.24	12798652.32	
Therapeutic Consultation Other Provider	hour	930	46.00	87.79	3755656.20	
Transition Services Total:						500.00

GRAND TOTAL: 1555746218.29

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122182.22

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Services	item	1	1.00	500.00	500.00	
Workplace Assistance Services Total:						1078242.66
Workplace Assistance Services	hour	66	393.00	41.57	1078242.66	

GRAND TOTAL: 1555746218.29
Total Estimated Unduplicated Participants: 12733
Factor D (Divide total by number of participants): 122182.22
Average Length of Stay on the Waiver: 352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Day Services Total:						116740882.72
Group Day Services	hour	5641	1037.00	19.80	115824396.60	
Group Day Services - Customized Rate	hour	22	1006.00	41.41	916486.12	
Group Home Residential Total:						768152809.29
Group Home Residential Customized Rate	day	163	217.00	781.83	27654108.93	
Group Home Residential	day	5802	311.00	410.38	740498700.36	
Individual Supported Employment Total:						5987705.22
Individual Supported Employment	hour	526	171.00	66.57	5987705.22	
Personal Assistance Services Total:						114439885.90
Consumer-Directed Personal Assistance	hour	2214	2615.00	16.29	94312746.90	

GRAND TOTAL: 1556059666.57
Total Estimated Unduplicated Participants: 12733
Factor D (Divide total by number of participants): 122206.84
Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services						
Personal Assistance Services	hour	433	2150.00	21.62	20127139.00	
Respite Total:						8439599.88
Respite Care	hour	289	221.00	21.24	1356577.56	
Consumer-Directed Respite Care	hour	1342	324.00	16.29	7083022.32	
Consumer-Directed Services Facilitation (until 5/31/27) Total:						1790350.80
Consumer-Directed Services Facilitation (until 5/31/27)	visit	2751	10.00	65.08	1790350.80	
Assistive Technology Total:						665061.60
Assistive Technology	service	280	2.00	1187.61	665061.60	
Benefits Planning Total:						21021.84
Benefits Planning	hour	43	8.00	61.11	21021.84	
Center-based Crisis Supports Total:						3086223.36
crisis Non-Professional	hour	62	182.00	29.04	327687.36	
crisis Professional	hour	86	300.00	106.92	2758536.00	
Community Coaching Total:						6274032.02
Community Coaching	hour	276	545.00	41.58	6254463.60	
Community Coaching Customized Rate	hour	1	278.00	70.39	19568.42	
Community Engagement Total:						31075963.45
Community Engagement	hour	2329	469.00	28.45	31075963.45	
Community Guide Total:						134183.28
Community Guide	hour	21	106.00	60.28	134183.28	
Community-Based Crisis Supports Total:						183216.00
crisis non-					1452.00	

GRAND TOTAL: 1556059666.57

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122206.84

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
professional	hour	5	10.00	29.04		
crisis professional	hour	170	10.00	106.92	181764.00	
Companion Services Total:						19311227.76
Companion Services	hour	244	1206.00	22.31	6565029.84	
Consumer-Directed Companion Services	hour	614	1291.00	16.08	12746197.92	
Crisis Support Services Total:						1194429.06
crisis non-professional	hour	33	473.00	31.06	484815.54	
crisis professional	hour	33	188.00	114.38	709613.52	
Electronic Home-Based Services Total:						193631.58
Electronic Home-Based Services	service	62	3.00	1041.03	193631.58	
Employment and community transportation Total:						32613.38
Public transportation	trip	5	6.00	2.42	72.60	
Trips 10-20 miles	trip	5	894.00	1.57	7017.90	
Trips under 10 miles	trip	8	737.00	1.79	10553.84	
Trips 20+ miles	trip	6	2572.00	0.97	14969.04	
Environmental Modifications Total:						193074.00
Environmental Modifications	service	50	1.00	3861.48	193074.00	
Group Supported Employment Total:						4202888.76
Group Supported Employment	hour	294	707.00	20.22	4202888.76	
In-home Support Services Total:						90028365.68
In Home Support Services Customized Rate	hour	2	4664.00	58.27	543542.56	
In Home Support Services	hour	1199	1928.00	38.71	89484823.12	

GRAND TOTAL: 1556059666.57

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122206.84

Average Length of Stay on the Waiver: 352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Peer Mentor Supports Total:						2323.70
Peer Mentor Supports	hour	5	19.00	24.46	2323.70	
Personal Emergency Response System Total:						971.40
Personal Emergency Response System	service	5	6.00	32.38	971.40	
Private Duty Nursing Total:						59293198.80
Private Duty Nursing	15 min	344	12045.00	14.31	59293198.80	
Shared Living Total:						2550.00
Shared Living	month	1	3.00	850.00	2550.00	
Skilled Nursing Total:						2135256.75
Skilled Nursing	15 min	207	605.00	17.05	2135256.75	
Sponsored Residential Total:						290401748.76
Sponsored Residential	day	2670	310.00	350.63	290216451.00	
Sponsored Residential Customized Rate	day	2	236.00	392.58	185297.76	
Supported Living Total:						14443400.40
Supported Living	day	143	292.00	345.90	14443400.40	
Therapeutic Consultation Total:						16554308.52
Therapeutic Consultation	hour	1899	57.00	118.24	12798652.32	
Therapeutic Consultation Other Provider	hour	930	46.00	87.79	3755656.20	
Transition Services Total:						500.00
Transition Services	item	1	1.00	500.00	500.00	
Workplace Assistance Services Total:						1078242.66
Workplace Assistance Services	hour	66	393.00	41.57	1078242.66	

GRAND TOTAL: 1556059666.57

Total Estimated Unduplicated Participants: 12733

Factor D (Divide total by number of participants): 122206.84

Average Length of Stay on the Waiver: 352