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 §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 waivers 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Changes noted within this renewal application were made to clarify and reflect current practice. In addition, more notable changes include the following:
(1) Updates to various Performance Measures, and
(2) Identifying activities within the services of Community Coaching, Group Day Services, Group Supported Employment, and Individual Supported Employment where telehealth is an appropriate model for service delivery.

The services under the Building Independence Waiver, VA.0430, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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 §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*):

Building Independence Waiver

C. Type of Request: renewal

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.0430
Draft ID: VA.007.04.00

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

Regular Waiver

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

07/01/23

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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 in42 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:

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 §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

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

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

  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §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 §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **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 Building Independence 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 goal of the Building Independence Waiver are to enable those community residents in need of supports, particularly those living on their own in the community to increase their options for independence and community integration through receiving those supports.

The objectives of the Building Independence 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 Building Independence 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.

Individuals may be supported by a CSB-employed or private support coordinator (case manager) under contract 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 §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 §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 §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 §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 in-patients 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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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:

Renewal Application Effective July 1, 2023

A public comment period for the proposed renewal application was made available from February 27, 2023 to March 29, 2023. Tribes in Virginia were also notified of these renewals on February 3, 2023 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, and Upper Mattaponi Tribe.

DMAS provided notice of public comment through an online notification posted to the agency's website for the duration of the thirty day period. The waiver application with amendments were available for public viewing on the DMAS agency website along with how to submit questions and/or comments via email, fax, and mail.

On February 27, 2023, DMAS and DBHDS sent emails to providers on the (1) DBHDS listserv; (2) Developmental Services Council email list; and (3) Developmental Disabilities Waivers Advisory Council regarding the public comment period for the renewal applications.

DMAS also solicited public comment in the Richmond Times-Dispatch, both the print edition and online through the newspaper's website. The print solicitation was published in the newspaper on Sunday, March 5, 2023. The online solicitation ran on the Richmond Times-Dispatch website from Monday, March 6, 2023 through Thursday, March 16, 2023. Instructions were provided both print and online on the methods to submit questions and comments as well as direct link to the waiver applications available on the DMAS website.

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:
Suite 1300

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: Waiver Operations Director

Agency: Dept. of Behavioral Health and Developmental Services

Address: PO Box 1797

Address 2:

City: Richmond

State: **Virginia**

Zip: 23218

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

Fax: (804) 692-0077

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

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will

continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The Virginia Department of Medical Assistance Services (DMAS), the state Medicaid authority, and Department of Behavioral Health and Developmental Services (DBHDS), the operating agency for the waiver, have worked together to develop a Statewide Transition Plan (STP). The STP outlines the status and needed actions to bring waiver services and providers into compliance with CMS's HCBS settings requirements. Virginia received initial approval from CMS for its STP in December 2016. This plan includes assessments and proposed actions for both agencies, as well as all affected providers. Virginia is in the process of updating its STP based on feedback and guidance from CMS to address outstanding questions, needed clarifications and provide an updated timeline. Activities supporting the state's effort to transition to compliance include:

1) mandatory provider self-assessment of compliance completed by 98% of providers and over 3,000 settings;
2) validation of provider organizational compliance underway;
3) new providers reviewed for HCBS compliance prior to enrollment with DMAS as a Medicaid provider; and
4) development of compliance resources & tools for stakeholders, individuals and families.

Virginia is intent on fully meeting CMS transition expectations through its comprehensive assessment of compliance status of current settings, robust and meaningful remediation strategies and transparent and interactive public comment and stakeholder involvement. Virginia's current DD waiver system is experiencing significant transition in response to a Department of Justice Settlement Agreement. The extended assessment timeframe has enabled Virginia to conduct its comprehensive assessment and align remediation strategies with new service definitions, rules, regulations, policy and systems re-design.

Residential services & supports: It has been determined that there are both settings that fully comply with the HCBS settings requirements and that do not comply and will require modifications. It is expected that remediation strategies will bring the majority/all settings into compliance.

Consistent with CMS guidance, Virginia is presuming that individuals own home/family home complies with the HCBS settings requirements and therefore these settings are not being assessed. Each setting is integrated with full access to the community, is chosen by the individual, ensures an individual's right to privacy, dignity, respect, and freedom from coercion and restraint, optimizes individual initiative, and facilitates individual choice. Group home, sponsored residential and supported living settings are being assessed and compliance status validated.

Group Day Services: It has been determined that there are both settings that fully comply with the requirements and settings that do not comply and will require modifications. It is expected that remediation strategies will bring the majority/all settings into compliance.

Group Supported Employment/Community-based work crew or enclave: It has been determined that there are both settings that fully comply with the requirements and settings that do not comply and will require modifications. It is expected that remediation strategies will bring the majority/all settings into compliance.

DBHDS developed a settings checklist that was distributed to all DBHDS-licensed providers of DD waiver residential and day support services, as well as DD waiver providers of group supported employment. The checklist was accompanied by an overview of the CMS Final Rule, including a link to the CMS toolkit website, and guidance information to assist the provider with understanding the intent of the requirements being evaluated in order to accurately complete of the checklist. The checklist was designed to help providers determine areas in which their setting(s) meet or require improvement in order to comply with the settings provision of the Final Rule. This checklist and accompanying guidance document incorporate all of the elements pertinent to settings, elements of the "Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community," as well as referring providers to the questions in the "Exploratory Questions to Assist States in Assessment of Residential Settings." Additional provider education webinars and materials were developed and distributed. A companion guide was developed to be used with as a side by side tool with the completion of the provider self-assessment in the fall of 2017. This self-assessment was completed by 98% of current providers and over 3,000 settings. A database with provider self-assessment responses and evidence is being maintained by the state for self-assessment validation.

Monitoring activities will help to ensure the provider self-assessment is accurate and settings do ultimately fully comply. Those providers found not to be in compliance with elements of the HCBS regulations will receive technical assistance from DHBDS staff. In addition, providers were sent a detailed break-down of the elements of the settings regulations in a planning tool format in order to encourage further initiation of the activities that will bring all into compliance and highlight the need for technical assistance.

Most settings impacted by the Final Rule (particularly those settings involving provider-owned or controlled residential settings) are licensed by DBHDS.

All providers licensed by DBHDS must comply with DBHDS Office of Human Rights regulations. DBHDS completed a cross-walk assessment of its current Human Rights regulations to the Final Rule. The current Human Rights regulations were found to be consistent with and supportive of the Final Rule elements.

DMAS DD waiver regulations require a greater emphasis on ensuring that individuals receiving HCBS have the same degree of access to an integrated community life as individuals not receiving Medicaid HCBS. Needed revisions to regulations will help to ensure that all HCBS, including day services, are integrated and meet settings requirements.

Most settings impacted by the Final Rule (particularly those settings involving provider-owned or controlled residential settings) are licensed by DBHDS.

The state has worked to develop:
*Develop cross agency subject matter expertise on the final rule and the transition plan;
*Ensure a collective understanding and consistent interpretation of requirements, transition plan milestones and guidance documents;
*Advise and support the education and training of professionals, providers and stakeholders;
*Ensure a cohesive and broadly represented approach toward compliance, monitoring and capacity issues; and,
*Ensure successful achievement of desired outcomes and full compliance with the HCBS final rule settings requirements.

Provider Sanctions and Disenrollment
Provider Enrollment & Licensing

The development of the compliance & monitoring team represents the state's intention to oversee, support and monitor full compliance with the settings requirements of the HCBS regulations. The team is empowered to:
• Provide technical assistance on the final rule including documentation for exceptions;
• Review and comment on developed materials and resources;
• Provide recommendations and assist with the development of solutions and implementation of strategies aimed at achieving desired outcomes;
• Oversee development and implementation of a communications strategy for providers, individuals and families regarding needed changes; and,
• Report to state leadership on the status of compliance.
• DBHDS Community Resource Consultants will be available to provide consultation to those providers that wish to comply, but are struggling with implementation.
• DMAS Long-Term Care Quality Management Review (QMR) staff will provide additional technical assistance and guidance to providers. QMR staff will provide technical assistance and guidance related to ensuring that the setting as a whole is complying and that the quality of Medicaid waiver participants' experiences with receipt of services are comparable to those not receiving Medicaid funded HCBS. This will occur primarily through review of provider records for waiver participants and documentation to support any individually assessed restrictions that may be in place per the individual's person-centered service plan.
• Office of Licensing staff will be able to assess and ensure that the provider implements and complies with the settings requirements also offering technical assistance, guidance and resources.

Provider Sanctions and Disenrollment

Providers not currently meeting the settings requirements will be asked to regularly report on the status of their compliance with the requirements through the completion of follow-up self-assessments. Those provider agencies that do not comply may receive a letter notifying them that they will likely forfeit their Medicaid Waiver provider status and be disenrolled. Providers will then have several choices. Providers may exercise the option to voluntarily terminate their Medicaid provider agreements. Providers whose self-assessment reveals issues that are not resolvable, may choose to relocate to settings that will enable them to more easily comply. In such instances, support coordinators/case managers working with individuals whose providers status is anticipated to change, will notify individuals receiving services and their families, as appropriate, of the provider's status and anticipated disenrollment/relocation date. The case manager and or support coordinator will work with the provider, individual, and family as appropriate, to ensure smooth transition to a setting that complies with the Final Rule. For providers who wish to maintain their Medicaid agreements, DBHDS will make every effort to assist them in coming into full compliance with the final rule, with mandatory disenrollment as an action of last resort. The provider sanctions and disenrollment process has been built into the final DMAS DD Waiver regulations and may be implemented as needed.

Provider Enrollment & Licensing

Virginia has developed and operationalized procedures to validate conformance with settings requirements into existing processes for provider enrollment and licensing. The developed and implemented changes have been designed to ensure that, as new providers enroll and are licensed, they fully meet the settings requirements. Efforts occurring within the state to increase provider capacity, although not part of this Transition Plan, will continue throughout the transition period.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Regarding the projected numbers for unduplicated beneficiaries in B-3: The state has learned through the 372 reports submitted to CMS during the last five year period for this waiver that it overestimated the number of persons who would enroll in the waiver. The state maintains a cap of 400 waiver slots for this waiver. In order to align more realistic projections for this five-year period closer to historical actual unduplicated beneficiary numbers, the state has lowered its unduplicated beneficiary projections. No individuals, provided they meet all level of care and eligibility standards, are to be removed from the waiver.

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.

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.

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)."

Note: The additional information below is a continuation of data from Appendix H, first section,
Appendix H Appendix H: Quality Improvement Strategy (2 of 2), H-1: Systems Improvement

Appendix H
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.

Mortality Review Committee (MRC)
In addition to the QRT-related activities described above, 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.
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. 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 and recent redesigning 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 distributes slots to CSBs, performs service authorization activities for the waiver and provides training, technical assistance and consultation.

The DMAS-DBHDS Interagency Agreement 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 Family and Individual Support Waiver, the Interagency Agreement lists DBHDS's responsibilities as:

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 behavioral health, developmental 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 information as 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/Behavioral Health Authorities (CSBs) 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 CSBs. DBHDS will monitor the assignment of slots by the CSBs 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) DMAS shall provide for payment of claims that meet all necessary criteria for payment of services.

19) DMAS shall conduct reviews of waiver operations consistent with waiver application and Medicaid regulations. Review may include Quality Management Reviews, Utilization Review and monitoring of the agreement.

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

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

According to the same Interagency Agreement, 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, Office 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 approved 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) As needed and/or requested, DMAS shall, in collaboration with DBHDS, monitor the costs associated with the DD 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 Medical Management System (VaMMIS) 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 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:

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 www.virginiamedicaid.dmas.virginia.gov.

○ **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:

The three main functions of the waiver administration and operation performed in part by the local Community Services Boards/Behavioral Health Authorities (CSBs) include:
1) Facilitating individual waiver enrollment;
2) Conducting the level of care evaluation; and
3) Coordinating the development of Individual Support Plans prior to service delivery.

These functions are completed by case managers/support coordinators 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/support coordination 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 and provider enrollment. DMAS also provides oversight of the MES/MMIS. 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 use 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.

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 and interagency agreements 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 management's 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.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☐	☒
Waiver enrollment managed against approved limits	☒	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☐	☐	☐
Level of care evaluation	☒	☒	☐	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
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 States quality improvement strategy, provide information in the following fields to detail the States 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:
3. Number and percent of slots allocated to CSBs in accordance with the standard, statewide slot assignment process N: # of slots assigned statewide according to the standardized process D: total # of slots assigned 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**

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:
1. 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: Every 6 months	

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:
2. 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**
	☐ **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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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 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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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	18		☒
	☒	Developmental Disability	18		☒
	☒	Intellectual Disability	18		☒
☐ 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	371
Year 2	391
Year 3	397
Year 4	

Waiver Year	Unduplicated Number of Participants
	399
Year 5	400

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	400
Year 2	400
Year 3	400
Year 4	400
Year 5	400

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).**

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 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, slots will be allocated to each region for individuals living within that region based upon a weighted formula which will factor the following objective factors and criteria:

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

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 group of CSBs within a region, 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 Advisory Committees (WSACs), review the needs of the highest scoring individuals within that region. The entity which places the individual on the waiting list (i.e., CSB) may not determine who receives the next available slot.

When the General Assembly has approved less than 40 slots for the Building Independence waiver, DBHDS will manage the turnover and distribution of this waiver's slots.

When a waiver slot becomes available through attrition, DBHDS will work with the region to determine if there is an individual appropriate for the slot in the region. If not, DBHDS will reassign the slot to a region with individuals who have requested access to a more integrated, independent living arrangement than can be supported through the provision of a minimal level of supports (i.e., through the BI waiver).

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 adults in the region in the Priority One category who have requested access to a more integrated, independent living arrangement that can be supported through the provision of a minimal level of supports have been offered and declined a BI waiver slot may Priority Two (and then Priority Three) individuals access a BI slot. The individual whose score indicates the highest need as designated by the committee, is offered the available slot. Any adult who was offered and passed on accepting a BI waiver slot, will remain on the waiting list for consideration for a slot from one of the other two DD waivers.

The committee reviews twice the number of people as available slots.

The three wait list priorities are described in more detail below:

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 that currently significantly limits the ability of the primary caregiver to care for the individual; or there are no other unpaid caregivers available to provide supports;
b. There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:
(1) The individual's behavior, presenting a risk to his/herself or others, cannot be effectively managed even with support coordinator-arranged generic or specialized supports; or
(2) There are physical care needs or medical needs that cannot be managed even with support coordinator-arranged generic or specialized supports;
c. The individual lives in an institutional setting and has a visible discharge plan; or
d. The individual is a young adult who is no longer eligible for IDEA services and has expressed a desire to live independently. After individuals attain 27 years of age, this criterion shall 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.

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 IDD 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

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ○ **§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)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **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 §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in**

§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 §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 §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, 2019 (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 §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 §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §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 periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §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 §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 (SSI 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 §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 periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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 periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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 §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 are 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 300% of SSI; for an individual employed at least 4 hours but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% 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 §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 435.726:

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 periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §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 §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 are 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 300% of SSI; for an individual employed at least 4 hours but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% 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:

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 five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §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 furnished at least quarterly. Case managers will continue to monitor all individuals enrolled in the waiver at least monthly. 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 a government agency under contract with the Medicaid agency.**

Specify the entity:

The CSB case manager (employed by or contracted with a CSB under contract with DMAS) performs the level of care evaluation. The selected case manager (CSB or private) performs the level of care reevaluation. The results of the evaluation/reevaluation are transmitted to DBHDS for review and confirmation 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, the individual employed as a case manager must have, at entry level, qualifications that are documented or observable to 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 training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;
5. Types of developmental disability, 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 receiving services.

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, 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 “Virginia Individual Developmental Disabilities Eligibility Survey” or “VIDES” is based on the Level of Functioning Survey and maintains the categories in that tool. Therefore, it is comparable to the LOF. The LOF is currently used for institutional eligibility. The state administrative code is in the process of being modified in order to adopt the VIDES for institutional use. 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.

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.

The instrument used to determine the waiver's level of care (the "Virginia Individual Developmental Disabilities Eligibility Survey" or "VIDES") was directly derived from the institutional level of care tool (the "Level of Functioning Survey" or "LOF"). The LOF was developed approximately 30 years ago and contained institutional language. The language was updated to be community-centric and person-centered. Nearly all young children (even those without disabilities) would meet the criteria under the LOF; therefore, age appropriate versions were created for children 3 through 17 ("Children's VIDES") as well as for infants birth to 3 (Infants' VIDES). Because of the age of the LOF and the fact that it was originally designed to assess individuals with ID only, elements of self-determination, which are particularly relevant for persons with non-ID developmental disabilities were not a component of the instrument. An additional category was added to the adult and children's versions of the VIDES regarding self-determination. The overall scoring was adjusted to ensure consistency of results between the VIDES and LOF. The Commonwealth is currently in the process of promulgating regulations to extend the use of the VIDES to those in ICF/IID settings so that, once again, there will be a single LOC tool for both waiver and institutional populations.

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 or other developmentally appropriate assessment for children) completed no earlier than 12 months prior to 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 and a psychological 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 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 are maintained in the electronic waiver management system).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
2. The number and percent of VIDES (LOC) 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:

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

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**	☐ **Annually**	☐ **Stratified**

Specify:		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:
2. 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 that use criteria appropriately to enroll or maintain a person in the waiver D: total # VIDES forms 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:

		A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
1. Number and percent 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 D: total # of VIDES forms 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: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

For those Performance Measures initially reviewed by case management entities, 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 as 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. 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. DMAS QMR staff follow up on all corrective action plans by reviewing records to ensure corrections have been made within 45 days. Serious violations (such as missing VIDES) may be referred to the DMAS Provider Integrity unit for billing 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**
	☐ **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 respectively by the VIDES and a psychological evaluation or other evaluation by a physician or other professional licensed to make the determination of developmental disability as defined by Virginia Code (§ 37.2-100), he or she:

1. Offers the individual (and legal guardian or family member/caregiver, as applicable) the choice of 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 waiver services, 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 in the applicable area of the state, 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 Home and Community-Based Waiver Choice of Providers" 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. Individuals who choose to receive services within an ICF/IID are provided these services in-state if available through private ICF/IID providers. If ICF/IID services are not available in-state, the individual has the opportunity to receive services in an ICF/IID located out of state.

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.

Both the "Documentation of Individual Choice between Institutional Care or Home and Community-Based Services" and "Virginia Informed Choice" forms are retained by the case manager for at least six years after the individual's final receipt of service for adults; forms are kept for children until 18 years of age plus six years. These are maintained in the case managers' records/EHR.

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 any prospective or current Medicaid participants Language Line Solutions services to provide over the phone interpretation services when communicating with DMAS or contracting entities. 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/vital Records/vtlapp.htm. Additionally, 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. Please see their web site for details. http://www.vdh.virginia.gov/ohpp/CLASact/default.aspx.

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 http://www.dbhds.virginia.gov/library/document-library/adm-sbpolicies1023.pdf for 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.

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	**Independent Living Supports**		
Statutory Service	**Individual Supported Employment**		
Other Service	**Assistive Technology**		
Other Service	**Benefits Planning**		

Service Type	Service		
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	Crisis Support Services		
Other Service	Electronic Home-based Supports		
Other Service	Employment and community transportation		
Other Service	Environmental Modifications		
Other Service	Group Supported Employment		
Other Service	Peer Mentor Supports		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Shared Living		
Other Service	Transition 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:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Group Day Services take place in non-residential settings, separate from the individual's home. They include skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability 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 day support may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Group Day Services should be coordinated with any physical, occupational, behavioral, or speech/language therapies listed in the person-centered plan. Meals are not provided as part of this service.

The allowable group day support services are:

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 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; and

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

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

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.

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.

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

The service unit is an hour. Group day services, alone or in combination with Community Engagement, Community Coaching and/or Supported Employment services are limited to no more than 66 hours per week.

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.

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.

Group Day Services occur one or more hours per day on a regularly scheduled basis for one or more days per week.

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.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 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 onsite 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):

Independent Living Supports

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Independent Living Supports is a service provided to adults (18 and older) with developmental disabilities that offers skill building and assistance necessary to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills. Individuals typically live alone or with roommates in their own homes or apartments. These services are not provided in licensed homes. The supports may be provided in the individual's residence or in community settings.

Allowable activities include:
- Skill building and supports to promote the individual's community participation and inclusion;
- Skill building and supports to increase socialization skills and develop/maintain relationships;
- Skill building and supports to increase/maintain the individual's health, safety and fitness;
- Skill building and supports to promote the individual's decision making and self-determination skills;
- Skill building and supports to promote the individual's engaging in meaningful community activities
- Skill building and supports related to ADLs and IADLs.

Allowable activities may be conducted in either a face-to-face or HIPAA-compliant telehealth method of delivery.

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

In general, individuals receive Independent Living Supports no more than 21 hours per week.

The unit of service is a month.

Activities using telehealth platforms are not to exceed 25% of the hours delivered in a month or half/month, limited to no more than 2 hours per day.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Independent Living Supports Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Independent Living Supports

Provider Category:
Agency
Provider Type:

Independent Living 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):*

Independent Living Supports providers must have a signed provider participation agreement with DMAS in order to provide 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 Independent Living 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.

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:

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:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported employment services are ongoing supports to individuals who need intensive ongoing support 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.

Individual supported employment is support usually provided one-on-one by a job coach to an individual in an integrated employment or self-employment situation. 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. This service is not time limited.

The allowable activities are:

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, 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 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.

The individual's assessment and individual support plan must clearly reflect the individual's need for employment-related skill building. Personal care is separate from this service.

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 services, alone or in combination with Community Engagement, Community Coaching 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 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.

Supported employment services through the waiver shall not available for used for incentive payments, subsidies, or unrelated vocational training expenses.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 Provider

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Supported employment providers must be a vendor of supported employment services with the Department of Aging and Rehabilitative Services (DARS).

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 providers of supported employment services meet criteria to be a vendor through a recognized accrediting 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:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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 individual’s 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.

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

The maximum Medicaid-funded expenditure for assistive technology is $5,000 per service plan year.

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.

In accordance with the CMS Informational Bulletin issued on July 7, 2014,assistive technology for individuals under age 21 shall be accessed through the state plan pursuant to ESPDT. Assistive technology 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**
- [x] **Provider managed**

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. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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, and the impact of other potential resource barriers around maintaining their 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.

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**

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 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10070 psychosocial rehabilitation
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 4:	**Sub-Category 4:**
11 Other Health and Therapeutic Services	11030 medication assessment and/or management

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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.
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 are:
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 behvior creating the crisi in areas such as self-care/ADLs, independent living skills, self-esteem building actiities, appropriate self-expression, coping skills, and medication compliance.

7. Supervision of the individual in crisis to ensure his or her safety and that of others in the environment.

Supervision of the individual in crisis to ensure his or her safety and that of others in the environment.

Center based crisis supports will ensure that all supports are individualized, follow person-centered service planning process, and will meet the HCBS regulations requirements (441.301(c)(4)(1) and 441.301(c)(4)(f).

This includes:
• Identify a specific and individualized assessed need.
• Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
• Document less intrusive methods of meeting the need that have been tried but did not work.
• Include a clear description of the condition that is directly proportionate to the specific assessed need.
• Include regular collection and review of data to measure the ongoing effectiveness of the modification.
• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
• Include the informed consent of the individual.
• Include an assurance that interventions and supports will cause no harm to the individual.

Intense Care Coordination under Center Based Crisis Supports would only be applicable to those individuals who did not have an active case manager until such time as they were connected to one.

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:

The unit of service is hourly.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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 Qualifications

License *(specify):*

Center-based crisis support providers for adults shall be licensed by DBHDS as providers of Group Home Service-REACH.

Center-based crisis supports shall be provided by a licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, certified pre-screener, QMHP, QDDP, or a DSP under the supervision of one of the professionals listed in this subsection.

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, a certified pre-screener, or QDDP.

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 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.

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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 behaviors, 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.

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.

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

The unit of service is an hour. Community Coaching, alone or in combination with Community Engagement, Group Day and/or Supported Employment services are limited to no more than 66 hours per week.

When both 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.

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.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 Coaching Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Coaching

Provider Category:
Individual
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 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 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 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:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
04 Day Services	04070 community integration

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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). 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. Community Engagement will be provided in general public community settings to which individuals with/without disabilities have access.

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; and (vi) maintaining contact with family and friends.
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.

Exploring community-based interests and activities and gathering general information about 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.

This service may include planning community activities with the individual, although this is limited to no more than 10% of the total number of authorized hours per week.

This service is delivered solely in community locations that are natural settings for the activities in which the individuals receiving this service are interesting in participating. This service is provided in general public community settings in which individuals with or without disabilities have access.

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 Community Coaching, Group Day 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. 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**

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):*

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 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 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 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 Guide

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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.

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 fifty 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**

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 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:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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. This service may be provided in all community settings including licensed and unlicensed homes, programs etc. 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 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 are:
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.

Community-based crisis supports differ from Crisis Support Services both in the individuals to whom they are provided and who provides them. Crisis Support Services are for individuals with episodic or situational based crises (death of a loved one, significant life change, etc) whereas Community-Based Crisis Supports is intended for people with more significant behavioral support needs who oftentimes have a dual diagnosis of mental health and DD. Additionally, crisis support services require QDDP credentialing of staff whereas community based crisis supports requires a more skilled person to assess and determine need for service (licensed or license- eligible staff) and must have both mental health and DD experience.

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 is limited to six months per year to be authorized in 30 day increments. Service unit is hourly.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 mental health outpatient/crisis stabilization services-REACH. 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 services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Community-based crisis supports shall be provided by a Licensed Mental Health Professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, a certified pre-screener, or QDDP.

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 supports 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 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.

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:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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 is provided in the community, in various day services and in various residential services, or in the individual's private/family home.

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.

Community-based crisis supports differ from Crisis Support Services both in the individuals to whom they are provided and who provides them. Crisis Support Services are for individuals with episodic or situational based crises (death of a loved one, significant life change, etc) whereas Community-Based Crisis Supports is intended for people with more significant behavioral support needs who oftentimes have a dual diagnosis of mental health and DD. Additionally, crisis support services require QDDP credentialing of staff whereas community based crisis supports requires a more skilled person to assess and determine need for service (licensed or license- eligible staff) and must have both mental health and DD experience.

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:
30 days per year of crisis prevention
90 days per year of crisis intervention
60 days per year of crisis stabilization (authorized in 15 day increments)

The service unit is hourly.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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 Supports 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 Supports Provider

Provider Qualifications

License *(specify):*

A crisis supports provider must be licensed by DBHDS as a provider of outpatient crisis stabilization services, crisis stabilization residential 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 supports services 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 supports 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.

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 Supports

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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.
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 for the safety afforded by the electronic monitoring.

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

The maximum Medicaid-funded expenditure for EHBS is $5,000 per year.

A preliminary needs assessment will be conducted by a technology specialist to help determine the best type and use of technology and the overall cost effectiveness of various options.

This waiver service shall not be used in licensed residential settings.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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 Supports

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 technology specialist conducting the preliminary assessment may be:

- an occupational therapist who is 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
(iii) a licensed home health provider; or
(iv) 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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	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:
Agency
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, an Employment Service Organization, or a Center for Independent Living. 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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Environmental modifications 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

4. 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.

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 shall not be used for the individuals work site, community activity setting or day program.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 Modifcation 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 Modifcation 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.

The contractor must:

1. Comply with all applicable state and local building codes, with accommodations to meet the individual's 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 ID 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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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. This service is not time limited.

The allowable activities are:

1. Vocational/job-related discovery or assessment;

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

3. Individualized job development 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 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.

The individual's assessment and individual support plan must clearly reflect the individual's need for employment-related skill building. Personal care is separate from this service.

Personal care is not typically provided as part of this service, but may be included.

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 and/or Group Day services are limited to no more than 66 hours per week.

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.

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 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.

Supported employment services through the waiver shall not available for used for incentive payments, subsidies, or unrelated vocational training expenses.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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):*

Supported employment providers must be a vendor of supported employment services with the Department of Aging and Rehabilitative Services (DARS).

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 providers of supported employment services meet criteria to be a vendor through a recognized accrediting 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:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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.

Allowable activities may be conducted in either a face-to-face or HIPAA-compliant telehealth method of delivery.

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**

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, an Employment Service Organization, or Center for Independent Living. 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. The training will be delivered by trained volunteers through the DBHDS Office of Recovery Services. In the application to become a Peer Mentor the applicant will be asked to detail his/her personal experience related to managing independent living, managing self-direction of supports, experience with finding and maintaining a job, accessing the community and building community supports.

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 (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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**
- [x] **Provider managed**

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 (PERS)

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.

A PERS provider shall be one of the following:
(i) an enrolled personal care agency;
(ii) an enrolled durable medical equipment provider;
(iii) a licensed home health provider; or
(iv) 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:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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. These expenses may be covered when the live-in companion 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 live-in companion will be agreed upon by the individual and the live- in companion, 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 live-in companion will not have the responsibility for providing habilitative services or medical services.

Shared living is different from Companion Services because Companion services are non-skill-building services (i.e., paid staff provide supports and general oversight) in an individual's home or other settings in the community. They may not include personal care types of tasks. Companion services' staff typically do not live with the individual they support. Although the Commonwealth has chosen to call the person delivering shared living services a "live-in companion," this is a very different service. The live-in companion does by definition live with the individual receiving waiver supports. He/she may provide a certain percentage of the service delivery time providing assistance with personal care tasks; however, the main objective of this service is to provide general fellowship, as a roommate would do, both in the home and in settings in the community. The "live-in companion" 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 live-in companion but to a provider agency that will in turn transfer the appropriate amount of funds to the individual.

The individual must reside in his or her own home or leased residence. Payment will not be made when the individual lives in the live-in companion'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 live-in companion must not be the individual's parent or spouse.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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 Provider

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

Provider Qualifications

License *(specify):*

Shared living administrative providers shall be licensed by DBHDS to provide services to individuals with DD.

Certificate *(specify):*

Other Standard *(specify):*

Coordinating agencies 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 and bill DMAS for Medicaid reimbursement.

The live-in companion 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 coordinating agency must ensure that there is a back-up plan in the event that the live-in companion is unable to provide supports.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services will verify coordinating agency qualifications.

Frequency of Verification:

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

DBHDS Office of Licensing staff may conduct unannounced onsite reviews of licensed coordinating agencies 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:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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**

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.

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: 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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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.

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.

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.

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; and, (c) the process for ensuring that mandatory screenings have been conducted. 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 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 as a part of QMR conducted by DMAS. All agency providers must also demonstrate the completion of CPS registry checks as a part of the enrollment process for a DMAS provider participation agreement.

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 (Appendix C-2-c) 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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.*

- ☐ **Self-directed**
- ☐ **Agency-operated**

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.*

Family members living under the same roof as the individual being served may not provide services unless there is objective written documentation completed by the case manager/support coordinator as to why there are no other providers available to provide services.

The individual's case manager/support coordinator is instrumental in ensuring that services are appropriate for individuals. 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 situations or serious extenuating circumstance exists that necessitates a family member as provider. The case manager/support coordinator must ensure that there was previously no barrier to the family member 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 as a paid support person and that the family member remains aware that there is a different relationship once he/she is paid to support the individual.

All BI waiver services must be authorized prior to delivery by DBHDS service authorization staff who review and compare individuals' assessment information, all available objective written documentation and their ISP outcomes/support activities. Staff authorize services which are in compliance with regulations and in accordance with the individuals' 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.

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.

Providers of services (unless identified under C-2 d) under any of the DD waivers shall not be parents or guardians of individuals enrolled in any of the DD waivers the waiver who are minor children, or the adult individual's spouse. Payment may only be made for services furnished by other family members who are living under the same roof as the individual receiving services if there is objective, written documentation as to why there are no other providers available to provide the care. This documentation must demonstrate that there are no other persons available to provide supports to the individual other than the unpaid family/caregiver who lives in the home with the individual. Examples of such documentation may be: (i) copies of advertisements and/or interview notes showing unsuccessful efforts to hire a consumer-directed assistant; (ii) documentation indicating high turnover in consumer-directed assistants or other paid staff; (iii) documentation supporting the individual's special medical or behavioral needs which can only be safely met by a family member;
(iv) documentation of the repeated inability to obtain service providers due to the family's remote location; (v) documentation of the failure of multiple providers to adequately provide supports to the individual or; (vi) documentation indicating that language is a factor in service delivery. Such family members, if approved to provide services for the purpose of receiving Medicaid reimbursement, shall meet the same provider requirements as all other licensed providers.

○ **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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
2. Number and percent of licensed/certified provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results. N = # licensed/certified provider agency staff who have criminal background checks as specified in policy/regulations with satisfactory results D = total # licensed/certified provider agency staff records reviewed

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

Responsible Party for	Frequency of data	Sampling Approach

data 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 =
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: A representative sample (95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:
3. Number and percent of enrolled licensed/certified provider agencies continuing to meet applicable licensure/certification following initial enrollment. N = # enrolled licensed/certified providers, continuing to meet applicable licensure/certification D = total # 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
1. Number & % of licensed/certified waiver agency provider enrollments for which appropriate lic./certif. was obtained in accordance with waiver reqmts prior to service provision. N = # of lic./cert waiver agency provider enrollments for which the appropriate lic./certif. was obtained in accordance with waiver reqmts prior to service provision D = total # of 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**

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:

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:
1. 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 # non-licensed/non-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: 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:

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:
1. Number and percent of provider agency staff, hired within 365 days of start date of QMR, meeting provider orientation training requirements. N: # provider agency staff meeting provider orientation training requirements D: total # 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** 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 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. Number and percent of provider agency direct support professionals (DSPs) with "proficiency confirmed", as part of the staff competency training requirements. N: # provider agency DSPs with proficiency confirmed as part of the competency training requirements. D: total # provider agency DSP 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 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**
	☐ **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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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's 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**	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.
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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The statewide transition plan is under review by CMS.

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

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 *(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. *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.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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.
- 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. Completion of these reviews occurs through an annual Support Coordinator Quality Review process that includes a look-behind sample completed 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.

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 micro board. 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 contributions, 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. 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; and, (g) how and when the plan is updated, including when the participant's needs change. 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.

(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, behavioral support needs as determined through the risk assessment, and interest in Supported Decision-Making. 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 at least 22 years of age or older has the Supports Intensity Scale® (SIS®) completed at least every four years or when the individual's needs change significantly. Each individual 16 years of age to 21 years of age has the Supports Intensity Scale® (SIS®) completed at least every three years 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 seven 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, Important TO/FOR, The Life I Want, and The Life I Don't Want.

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. "Important TO/FOR" describes what is important to and important for the person across seven life areas. The Life I Want description captures 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, "The Life I Don't Want" considers what should be avoided since it does not lead or contribute to the person's desired life.

(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. This is documented on the “Virginia Informed Choice” form.

(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 achieve each outcome, who will support in each instance, 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 non-waiver 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, personal assistance, day support, 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 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.

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. 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. DBHDS Office of Licensing staff make annual unannounced onsite reviews in order to ensure provider compliance with these regulations, as well as evaluate the physical facilities in which the services are provided

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 health, 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 or elsewhere 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 effect 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 providers' Plan for Supports as applicable. 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. 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.

Individuals enrolled in this waiver participate in the Commonwealth Coordinated Care Plus managed care program with the exception of those in excluded populations. Services provided through this waiver are carved out of the program and are provided on a fee for service basis. Each individual enrolled in the managed care organization (MCO) is supported by a managed care coordinator (MCC) who completes a comprehensive Health Risk Assessment for individuals served.

Issues identified are included in the MCO's Individual Care Plan.

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 DMAS website, Virginia's My Life My Community website, and 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.

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. A 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 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.

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 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 and participant health and welfare; (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.

Case managers are urged to conduct their quarterly face-to-face visits with individuals in a variety of locations, such as at the person's day services or job site, as well as at his home. This offers the opportunity to see the individual receiving services in order to verify that the plans are being delivered. This may also provide opportunities to discuss service provision with the individual's providers and/or family members.

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 the supports and services he needs, whether those services are waiver-funded or not. Examples of common non-waiver-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/authorized representative 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 or neglect 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 through the provision of an On-Site Visit Tool along with any necessary reporting regarding concerns with service delivery. Data submitted (for a sample of each CSB's individuals receiving waiver services) include 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 Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
4. Number and percent of service plans that include a back-up plan when required for services to include in home supports, personal assistance, respite, companion, and shared living. N = # of service plans that include a back-up plan when required D = total # of service plans reviewed that require a back-up plan

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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:
2.Number and percent of individual records that indicate that a risk assessment was completed as required. N: # of records that indicate that a risk assessment was completed as required D: total # of 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:

		A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
1. Number and percent of individuals who have service plans that address their assessed needs, capabilities and desired outcomes. N: # of individuals who have service plans that address their needs, capabilities, and desired outcomes D: total # 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: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:
3.Number and percent of individuals whose plan for supports includes a risk mitigation strategy when the risk assessment indicates a need N: # of individuals whose service plan includes a risk mitigation strategy when the risk assessment indicates a need D: total # of individuals' records reviewed whose risk assessment indicates a need for a risk mitigation strategy

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

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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 =
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

b. ***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.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

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:
1. Number and percent of service plans reviewed and revised by the case manager by

the individual's annual review date N = # of service plans reviewed and revised by the case manager by the individual's annual review date D = total # 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: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:
2. Number and percent of individuals whose service plan was revised, as needed, to address changing needs. N: # individuals whose service plan was revised, as needed, to address changing needs D: total # individual service plans reviewed that needed to be revised due to changing needs.

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 = Confidence interval =95%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

d. ***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:
2. Number and percent of individuals who received services in the duration specified in the service plan N: # individuals who received services in the duration specified in the service plan D:# 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: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:
1. Number and percent of individuals who received services in the frequency specified in the service plan N: # individuals who received services in the frequency specified in the individual service plan D: # 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:

		A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
4. Number and percent of individuals who received services in the scope specified in the service plan N: # individuals who received services in the scope specified in the service plan D:# 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: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:
5. Number and percent of individuals who received services in the amount specified in the service plan N: # individuals who received services in the amount specified in the service plan D:# 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: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:
3. Number and percent of individuals who received services of the type specified in the service plan N: # individuals who received services of the type specified in the service plan D:# 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:

		A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

e. ***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:
1. Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual. N = # of case management records that contain documentation that choice of waiver providers was offered to the individual D = total # of 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:

		A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
2. Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services. N = # of case management records that contain documentation of choice among waiver services D = total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and off-site Quality Management Reviews

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:

		A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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. DMAS QMR staff follow up on all corrective action plans by reviewing records to ensure corrections have been made within 45 days. 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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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 Virginia Administrative Code § 12VAC 30-110-70 through 90 and federal regulations, Code of Federal Regulations 42 CFR Part 431, Subpart E requires a "Notice of Appeal Rights" be sent to individuals who have an adverse action related to choice of 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 translated into their native language or if they are not literate, an interpreter must be provided to explain their rights 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 the agency intends to take;
2. The reason(s) for the intended action written in clear/plain language;
3. An explanation of the individual's right to request a hearing;
4. An explanation of the circumstances under which Medicaid is continued if a hearing is requested;
5. An explanation of the individual's requirement to reimburse DMAS if the agency's action is upheld, if the individual continues to receive a Medicaid-covered service; and
6. The effective date of the action.

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. When the individual's request for admission into a Medicaid-covered service or when the individual's request for an increase in a Medicaid-covered service is denied or not acted upon promptly for any reason (i.e., diagnostic or functional eligibility, funding, no provider, etc.).

All notification letters must be filed in the case management/support coordination record.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write 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. A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:
Appeals Division
Department of Medical Assistance Services

600 E. Broad Street
Richmond, Virginia 23219
Appeal requests may also be faxed to: (804) 371-8491

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 the following paragraph,

"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 will be expected 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**

b. 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.

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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

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.

DMAS refers any complaints/grievances received to the operating agency, DBHDS. DBHDS is the primary agency that receives complaints and grievances. 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.

c. 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).

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 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.

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. Protective services for adults are described in the Virginia State Code at §63.2-1605.

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.

Virginia defines these terms for adults as follows:
"Abuse" means (i) knowing and willful conduct that causes physical injury or pain or (ii) knowing and willful use of physical restraint, including confinement, as punishment, for convenience or as a substitute for treatment, except where such conduct or physical restraint, including confinement, is a part of care or treatment and is in furtherance of the health and safety of the incapacitated person. [§18.2-369]

"Incapacitated adult" means any person 18 years of age or older who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age or other causes to the extent the adult lacks sufficient understanding or capacity to make, communicate or carry out reasonable decisions concerning his well-being. [§18.2-369]

"Neglect" means the knowing and willful failure by a responsible person to provide treatment, care, goods or services which results in injury to the health or endangers the safety of an incapacitated adult [§18.2-369].

"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 DARS offices of Adult Protective Services 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.

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.

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 and 10 days after the investigation closes to notify the responsible parties of the results.

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 or neglect 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 or neglect 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. Deaths and serious injuries 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 and place of death or serious injury; nature of injuries and treatment required and circumstances of death or serious injury.

3. Each instance of 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, DARS, 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, DARS 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.

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 Protective Services, the local human rights committee or other direct care providers or professionals, to register a complaint on his or her behalf.

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 elderly 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, includes information about abuse, neglect and exploitation as well as the APS 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 in need or not in need of protective services at case closure. APS has 45 days to complete the investigation and 10 days after the investigation closes to notify the complainant of the results.

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. DBHDS staff conducts announced and unannounced onsite 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. 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.

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.

Current waiver regulations 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.

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 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:

1. Providers shall not use restraint as a punishment or reprisal or for the convenience of staff.
2. Providers shall not use restraint solely because criminal charges are pending against the individual.
3. 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.
4. 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.
5. 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.
6. 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 either the Mandt or Therapeutic Options [See http://www.therops.com/therapeuticoptions.html] systems. 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 12VAC35-115-50 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.

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 disAbility Law Center of Virginia.
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 legal guardian 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.

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 time out as a punishment or reprisal or for the convenience of staff.

2. Providers shall not use time out 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 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 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 regarding the use of time out 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 time out.

2. Providers shall document in the individual’s services record all known contraindications to the use of . . . time out including medical contraindications and a history of trauma and shall flag the record to alert and communicate this information to staff.

3. Providers shall not use time out as a punishment or reprisal for the convenience of staff.

4. 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.

5. Each use of time out shall end immediately when criteria for removal are met.

6. Providers shall ensure that no individual is in time out for more than 30 minutes per episode.

Below are the definitions of “Time out” and “seclusion” as well as further description of how they are different and the protocols required to appropriately conduct a “time-out”.

Definitions:
"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 (Delmarva) to conduct on-site "Person Centered Reviews" and "Provider Quality Reviews" throughout the year. Delmarva 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 Delmarva (see response to question #19), 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 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) advocate, monitor, review, consult and investigate, as appropriate. A trained investigator, investigates the allegation and makes a recommendation to the provider.

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.)*

◉ **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)*

b. 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.

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 are conducted on a random sample of providers throughout the year. 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)*

ii. 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;
-staff 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.

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.

iii. 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;
-staff shall contact a poison control center or the appropriate medical personnel and take actions as directed;
-the individual's physician shall be notified as soon as possible;
-actions taken by staff shall be documented;
-errors must be recorded in the individual's medication log; and
-the provider shall review medication errors at least quarterly.

iv. 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.

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 States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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:
2. Number and percent of substantiated cases of abuse/neglect/exploitation for which the required corrective action was verified by DBHDS as being implemented. N = number of substantiated cases of abuse/neglect/exploitation for which the required corrective action was verified as being implemented within 90 days D = number of substantiated cases of abuse/neglect/exploitation

Data Source (Select one):
Other
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** Specify:

Performance Measure:
3. # &% 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
1. Number and percent of closed cases of abuse/neglect/exploitation for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations. N = number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with regulations D = number of closed cases of abuse/neglect/exploitation 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:
	☒ **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:
4. Number and percent of individuals whose service record contains a current notification of rights and information to report ANE N= Number of records containing documentation confirming notification of rights and how to report ANE. D= Total number of records received.

Data Source (Select one):
Record reviews, off-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: A representative sample(95/5) of total CL, FIS, BI waiver enrollees. Using a percent of the total each waiver represents, a calculation will be made for the # of enrollees to review for each waiver.
	☐ **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 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:
1. Number and percent 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 timeframe. 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

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:

2. # and % of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly. N: # of licensed DD providers that administer medications not 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):
Record reviews, on-site
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:

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:
1. Number and percent of individuals reviewed who did not have unauthorized restrictive interventions. N = number of individuals reviewed who did not have unauthorized restrictive interventions. D = number and percent 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 staff. 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:
	☒ **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**
☒ **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:
2. 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 + complaints submitted via CHRIS

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:

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:
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**

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.

Subassurance (a) 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 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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. 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's Provider Integrity unit for billing 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **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 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 §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 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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 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; case management data reporting; quality service reviews (QSR), and mortality reviews.

Performance measure (PM) data used to support the CMS waiver assurances is reviewed by the Quality Review Team (QRT). Following the end of each quarter, the QRT reviews data related to the waiver assurances. 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 Community Quality Development, Office of Provider Development, and the Office of Clinical Quality Management. When performance under any of the PMs 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 allegations of 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 and assist in the complaint resolution process by monitoring provider reporting and reviewing provider investigations and corrective actions. Advocates also respond to reports of abuse by conducting independent or joint investigations with DBHDS partners and/or Virginia Department of Social Services (VDSS). In cases where there are violations of the Human Rights Regulations, Advocates recommend citation through the Office of Licensing. At the QRT meeting, the OHR reports on provider reviews conducted during the previous quarter once complaints are resolved and cases closed.

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
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 Improvement (CQI) 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 in Virginia:
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 have been established in each of the five DBHDS regions in Virginia. RQC membership includes DBHDS staff, DD waiver providers, and individual and family stakeholders. 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 DBHDS Office of Data Quality and Visualization (DQV) is a resource for assisting staff in developing a plan to monitor and analyze the effectiveness of system changes. DQV assists programs to develop questions and further plan their analyses. This process has been facilitated by the DBHDS OneSource Data Warehouse providing ease of access to a wide breadth of information about providers and individuals receiving services. DQV assists DBHDS programs that provide data to the QRT identify, evaluate, refine, and document processes that already exist in their respective areas, as well as assists in determining where improvements are needed and establishing a plan for monitoring data quality, which is then reported back to the QRT and/or the QIC. Results are evaluated over time to determine whether the system changes are having their intended impact. When the desired outcomes are not achieved, staff will seek input from relevant stakeholders to determine additional barriers that are affecting performance, identify, and implement additional actions. The QRT and QIC are is responsible for monitoring and assessing quality improvement plans that lead to assuring the successful implantation 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 fraud 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 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.

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. 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.

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 abuse 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

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:
1. 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 claims reimbursed using the approved rate D = Total number of adjudicated claims

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for	***Frequency of data***	***Sampling Approach****(check*

data collection/generation *(check each that applies):*	***collection/generation*** *(check each that applies):*	*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:
2. Number and percent of adjudicated waiver claims that were submitted using the correct procedure codes. D=Total number of adjudicated claims that were submitted using the correct procedure codes. N=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***
☐ ***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:
1. 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 D: Total # 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 =*
☐ ***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:*

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The Program Integrity Division will take action to retract payment when necessary, refer cases of concern to the Medicaid Fraud Unit or offer provider education as needed. Virginia has a very low loss ratio, which is considered to be a testament to the effectiveness of these efforts.

In reference to PM #2: Number and percent of claims paid that are for authorized services. N: # of claims paid that are for authorized services; D: total # of claims paid.

All claims paid through the VAMMIS system pass through numerous claims processing edits. Most of the waiver services require prior service authorization before a provider can bill for the service. This prior service authorization requirement is carried over to the claims processing system and is one of the system edits that are checked prior to claims resolution.

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 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. A complete listing of all current waiver services rates are maintained on the DMAS Web site (http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx) and is available to the public for review. Individuals may call DMAS 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 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 is used in new rates. The rate study encompassed several activities, including varied opportunities for public comment.

- *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 second survey directed towards consumer-directed services facilitation providers was administered in 2016 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 seven levels based on assessment results in the areas of home living support needs, community living support needs, health and safety needs, medically-related support needs, and behaviorally-related support needs. These seven levels, in turn, are cross-walked to four rate categories: low needs (level 1), modest needs (level 2), moderate to significant needs (levels 3 and 4), and highest needs (levels 5, 6, and 7.*
- *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, B&A 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:

- *Independent Living Supports*
- *Shared living*
- *Crisis Supports (Community-based Crisis supports, Center-based Crisis Supports, Crisis Support Services)*
- *PERS*
- *Group supported employment*
- *Community engagement*
- *Group day support*
- *Benefits planning services*

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. For example, the rate models were revised in March 2016 to account for more current BLS wage information and a change in the Internal Revenue Services. 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.

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 on an annual basis through a Purchase of Service Application, which is similar to a cost report. The hourly rate is 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. .*

- *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 the services are new, there was nothing to 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 Employment and 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.

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 services (Assistive Technology, Environmental Modifications and Transition Services) for which the CSBs may act as a conduit between DMAS and nonprovider agencies in the community. Providers submit claims on the CMS-1500 to the private contractor, Xerox, the fiscal agent for DMAS. Xerox 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.

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.

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 through MMIS, 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. The QMR process begins with identifying a random sample of active waiver individuals to determine the percentage of records to be reviewed. A statistically valid sample is generated using the Statistical Analysis System® (SAS) to run a report that provides a random selection of individuals and service providers. 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 DD waivers 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 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.

Individuals seeking case management services through the Community Services Board Single Point of Entry are offered a choice of case manager.

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:

○ ***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:

☐ ***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: residential supports, respite, day supports, supported employment, crisis stabilization, assistive technology, environmental modifications, behavior 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

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 ID 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 §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 §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 §1915(b)/§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 §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 ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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:*

Do not complete this item.

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) (Tidewater) 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 Tidewater (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, Burns and Associates, 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.

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	21770.67	13929.00	35699.67	232555.00	7858.00	240413.00	204713.33
2	21798.31	13929.00	35727.31	232555.00	7858.00	240413.00	204685.69
3	21813.30	13929.00	35742.30	232555.00	7858.00	240413.00	204670.70
4	21842.47	13929.00	35771.47	232555.00	7858.00	240413.00	204641.53
5	21842.11	13929.00	35771.11	232555.00	7858.00	240413.00	204641.89

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	371	371
Year 2	391	391
Year 3	397	397
Year 4	399	399
Year 5	400	400

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 average length of stay on the waiver is based on the actual average length of stay reported on the CMS-372 for SFY 2014 - SFY 2016.

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:*

The Commonwealth limits the number of participants that it serves at any point in time during a waiver year. As of July 1, 2017 (FY 2018), the budget authorized 360 participants to be served at any point during the year. The final budget passed by the Virginia General Assembly and signed by the Governor for FY 2019 and FY 2020 (waiver year 1 and 2) included funds to increase the number of available BI slots by 40 in FY 2019 (WY1). Because the budget does not authorize any additional slots beyond the 40 additional in FY19, Appendix B-3-b reflects a maximum of 400 participants in the waiver at any point during all 5 years included in this period. In estimating the number of unduplicated participants, since no new slots are assumed to be added, it is assumed that 100% of those slots are filled in WY1 and then they are gradually filled to 105% by WY5. It is assumed that unduplicated participants would equal 105% of available slots in a year where all slots are filled, as slots may have more than one individual using the slot in the year as individuals exit and enter the waiver throughout the year.

In 2016, DBHDS analyzed FY 2014 claims data to establish baseline users and units estimates at the service level for the first 5 years of the redesigned BI waiver. The ratios of users to enrollment and units to user were assumed to be constant over the waiver period. Cost information reflects the results of DBHDS' provider rate study.

When DHBDS conducted its analysis of 2014 claims, the number of individuals receiving services, the number of users of each covered service, and the number of units used for each service were determined. For existing services the State has assumed that the ratio of users to total enrollees will remain constant, as will the number of units consumed per user. Unit costs are based on the State's fee schedule. DBHDS conducted a review of provider payment rates in 2014 and 2015. Based on the results of the review, a new fee schedule was established. The General Assembly provided funding for the implementation of the new rates, which will began July 2016.

The average cost per unit estimates are directly based on the fee schedule, accounting for estimated distributions of services in Northern Virginia and the rest of the State and other applicable factors (such as members' levels of need or group home size). Estimated distributions are based on analyses of claims data, the results of Supports Intensity Scale assessments included in a pilot study, and provider survey results.

The State's preliminary data for 2017 shows 263 unduplicated participants in the BI waiver in that year. In 2017, 300 BI slots were available, meaning that 87.7% of available slots were filled during the year. In 2018, the Virginia General Assembly provided funds and authorization to increase the number of BI slots to 360 in that year. The average annual percent of slots filled in 2014 through 2017 (89.42%) was used to determine that 322 unduplicated participants are expected in 2018.

The State assumes that these slots will gradually fill to capacity over time. The State models this by assuming the number of slots will remain constant at 360 over the entire 5 years of the waiver renewal. Then, we assume that in the first year of the increased number of available BI slots, 2018, that the percent of slots filled will equal the average percentage of filled slots for 2014-2017. Next, because services have been added to the BI waiver to create a more robust continuum of services, we assume that as individuals learn about the redesigned waivers, more individuals will enroll in the waiver. We assume that by Waiver Year 5/2023, the fill rate of BI slots will be 105% (more than 100% because some individuals may not stay on the waiver for the whole year and a slot may be used by more than one person in a year). To model the gradual filling of slots over the 5 year timeframe, we took the difference between 105% (the WY5 fill rate) and 89.4% (the 2018 estimated fill rate), divided by 5 (arriving at 3.1%), and added that percent to the fill rate in each year (so, for WY1, we added 3.1 percentage points to the estimated 2018 fill rate of 89.4% to arrive at a fill rate of 92.5%).

The State assumes that units per user would remain relatively constant over time. The State has not identified any policy goals or other factors that would impact utilization. As a result, the State has assumed that units per user will remain constant over time.

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:*

Historical trend and usage patterns of acute care services for the BI waiver have reflected over 10% increases in per person spending in FY 2014 - FY 2016. As new services have been added to this waiver, the usage of acute care services should slow. The per person spending trend for individuals served in the FIS waiver in SFY 2012 - SFY 2017 were used to determine the trend in per person acute care spending for the BI waiver in FY19-FY23 (WY1-WY5) because the populations served in these two waivers are relatively similar, and their acute care spending patterns are expected to be similar.

The State used Factor D' data from 2014, 2015, and 2016 372 Reports, plus preliminary 372 data for 2017 Factor D'. The preliminary 372 data used for 2017 is MMIS claims data for claims with service dates and paid dates in 2017. This preliminary data does not contain lag claims data (claims with a service date in 2017 that have a paid date in the next fiscal year) normally included in the 372 report because it is not available for 2017 yet. This data was used to establish what the starting point for future year estimates should be.

However, in determining what to use for an annual growth rate for Factor D', we used 2012-2017 data from the FIS waiver's 372 reports. When we reviewed the average annual rate of change for the BI waiver, it appeared to include outliers that would result in an inappropriately high growth rate of 15.3%. We believe that with the waiver redesign and effort to place individuals in waivers based on their needs that the growth in the utilization of acute care services will slow. The average annual rate of change in Factor D' for the FIS population over a longer time period (2012 - 2017) appeared to be a more reasonable growth factor to use the BI waiver going forward.

Expenditures for Part D are paid for and recorded to a unique accounting code. Payments in that accounting code were excluded from historical expenditures used to estimate Factor D'.

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:*

Calculations and projections are updated based on historical expenditure trends and utilization patterns of individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) as reported in the CMS-372 for SFY 2012 - SFY 2016.

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:*

Calculations and projections are updated based on historical expenditure trends and utilization patterns of individuals with intellectual disability in ICFs/IID) as reported in the CMS-372 for SFY 2012 - SFY 2016. However, data from SFY 2015 was not included to determine a trend because per person expenditures in that year increased 24% over the previous year. In the following year, SFY 2016, the change in per person expenditures resumed a pattern more similar to the years preceding 2015, so it was determined that the change in per person expenditures in 2015 was an outlier and it was not included.

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	
Independent Living Supports	
Individual Supported Employment	
Assistive Technology	
Benefits Planning	
Center-based Crisis Supports	
Community Coaching	

Waiver Services	
Community Engagement	
Community Guide	
Community-based Crisis Supports	
Crisis Support Services	
Electronic Home-based Supports	
Employment and community transportation	
Environmental Modifications	
Group Supported Employment	
Peer Mentor Supports	
Personal Emergency Response System (PERS)	
Shared Living	
Transition 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:						2285616.60
Group Day Services	hour	180	743.00	17.09	2285616.60	
Independent Living Supports Total:						3846074.96
Independent Living Supports	month	182	13.00	1625.56	3846074.96	
Individual Supported Employment Total:						873804.12
Individual Supported Employment	hour	84	167.00	62.29	873804.12	
Assistive Technology Total:						27131.76
Assistive Technology	service	9	2.00	1507.32	27131.76	
Benefits Planning Total:						7356.70
Benefits Planning	hour	13	10.00	56.59	7356.70	
Center-based Crisis Supports Total:						107132.16
				GRAND TOTAL:		8076917.93
				Total Estimated Unduplicated Participants:		371
				Factor D (Divide total by number of participants):		21770.67
				Average Length of Stay on the Waiver:		327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Supervision	hour	5	89.00	24.84	11053.80	
Crisis Intervention	hour	6	161.00	99.46	96078.36	
Community Coaching Total:						17168.00
Community Coaching	hour	2	200.00	42.92	17168.00	
Community Engagement Total:						636222.24
Community Engagement	hour	72	362.00	24.41	636222.24	
Community Guide Total:						58370.00
Community Guide	hour	20	50.00	58.37	58370.00	
Community-based Crisis Supports Total:						6300.65
Crisis Intervention	hour	5	11.00	108.91	5990.05	
Crisis Supervision	hour	1	10.00	31.06	310.60	
Crisis Support Services Total:						1465.74
Crisis Supervision	hour	1	3.00	31.06	93.18	
Crisis Intervention	hour	4	3.00	114.38	1372.56	
Electronic Home-based Supports Total:						21937.00
Electronic Home-based Supports	service	10	2.00	1096.85	21937.00	
Employment and community transportation Total:						2182.24
Rides 10 miles and under	trip	1	451.00	2.74	1235.74	
Rides 10-20 miles	trip	1	350.00	1.05	367.50	
Rides over 20 miles	trip	1	300.00	0.99	297.00	
Public transportation	trip	1	300.00	0.94	282.00	
Environmental Modifications Total:						4789.79
Environmental Modifications	service	1	1.00	4789.79	4789.79	
Group Supported Employment Total:						169881.20

GRAND TOTAL:	8076917.93
Total Estimated Unduplicated Participants:	371
Factor D (Divide total by number of participants):	21770.67
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Supported Employment	hour	20	478.00	17.77	169881.20	
Peer Mentor Supports Total:						122.35
Peer Mentor Supports	hour	1	5.00	24.47	122.35	
Personal Emergency Response System (PERS) Total:						35.05
Personal Emergency Response System (PERS)	service	1	1.00	35.05	35.05	
Shared Living Total:						11227.37
Shared Living	month	1	11.00	1020.67	11227.37	
Transition Services Total:						100.00
Transition Services	service	1	1.00	100.00	100.00	
				GRAND TOTAL:		8076917.93
				Total Estimated Unduplicated Participants:		371
				Factor D (Divide total by number of participants):		21770.67
				Average Length of Stay on the Waiver:		327

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:						2412595.30
Group Day Services	hour	190	743.00	17.09	2412595.30	
Independent Living Supports Total:						4057397.76
Independent Living Supports	month	192	13.00	1625.56	4057397.76	
Individual Supported Employment Total:						925816.27
Individual Supported Employment	hour		167.00	62.29	925816.27	
				GRAND TOTAL:		8523139.72
				Total Estimated Unduplicated Participants:		391
				Factor D (Divide total by number of participants):		21798.31
				Average Length of Stay on the Waiver:		327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		89				
Assistive Technology Total:						27131.76
Assistive Technology	service	9	2.00	1507.32	27131.76	
Benefits Planning Total:						7922.60
Benefits Planning	hour	14	10.00	56.59	7922.60	
Center-based Crisis Supports Total:						107132.16
Crisis Supervision	hour	5	89.00	24.84	11053.80	
Crisis Intervention	hour	6	161.00	99.46	96078.36	
Community Coaching Total:						25752.00
Community Coaching	hour	3	200.00	42.92	25752.00	
Community Engagement Total:						671567.92
Community Engagement	hour	76	362.00	24.41	671567.92	
Community Guide Total:						61288.50
Community Guide	hour	21	50.00	58.37	61288.50	
Community-based Crisis Supports Total:						6300.65
Crisis Intervention	hour	5	11.00	108.91	5990.05	
Crisis Supervision	hour	1	10.00	31.06	310.60	
Crisis Support Services Total:						1465.74
Crisis Supervision	hour	1	3.00	31.06	93.18	
Crisis Intervention	hour	4	3.00	114.38	1372.56	
Electronic Home-based Supports Total:						21937.00
Electronic Home-based Supports	service	10	2.00	1096.85	21937.00	
Employment and community transportation Total:						2182.24
Rides 10 miles and under	trip	1	451.00	2.74	1235.74	
Rides 10-20 miles					367.50	

GRAND TOTAL:	8523139.72
Total Estimated Unduplicated Participants:	391
Factor D (Divide total by number of participants):	21798.31
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	trip	1	350.00	1.05		
Rides over 20 miles	trip	1	300.00	0.99	297.00	
Public transportation	trip	1	300.00	0.94	282.00	
Environmental Modifications Total:						4789.79
Environmental Modifications	service	1	1.00	4789.79	4789.79	
Group Supported Employment Total:						178375.26
Group Supported Employment	hour	21	478.00	17.77	178375.26	
Peer Mentor Supports Total:						122.35
Peer Mentor Supports	hour	1	5.00	24.47	122.35	
Personal Emergency Response System (PERS) Total:						35.05
Personal Emergency Response System (PERS)	service	1	1.00	35.05	35.05	
Shared Living Total:						11227.37
Shared Living	month	1	11.00	1020.67	11227.37	
Transition Services Total:						100.00
Transition Services	service	1	1.00	100.00	100.00	
				GRAND TOTAL:		8523139.72
				Total Estimated Unduplicated Participants:		391
				Factor D (Divide total by number of participants):		21798.31
				Average Length of Stay on the Waiver:		327

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:						2450688.91
Group Day Services	hour	193	743.00	17.09	2450688.91	
Independent Living Supports Total:						4120794.60
Independent Living Supports	month	195	13.00	1625.56	4120794.60	
Individual Supported Employment Total:						936218.70
Individual Supported Employment	hour	90	167.00	62.29	936218.70	
Assistive Technology Total:						27131.76
Assistive Technology	service	9	2.00	1507.32	27131.76	
Benefits Planning Total:						7922.60
Benefits Planning	hour	14	10.00	56.59	7922.60	
Center-based Crisis Supports Total:						123145.22
Crisis Supervision	hour	5	89.00	24.84	11053.80	
Crisis Intervention	hour	7	161.00	99.46	112091.42	
Community Coaching Total:						25752.00
Community Coaching	hour	3	200.00	42.92	25752.00	
Community Engagement Total:						680404.34
Community Engagement	hour	77	362.00	24.41	680404.34	
Community Guide Total:						61288.50
Community Guide	hour	21	50.00	58.37	61288.50	
Community-based Crisis Supports Total:						6300.65
Crisis Intervention	hour	5	11.00	108.91	5990.05	
Crisis Supervision	hour	1	10.00	31.06	310.60	
Crisis Support Services Total:						1465.74
Crisis Supervision	hour	1	3.00	31.06	93.18	
Crisis Intervention					1372.56	

GRAND TOTAL:	8659882.08
Total Estimated Unduplicated Participants:	397
Factor D (Divide total by number of participants):	21813.30
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	hour	4	3.00	114.38		
Electronic Home-based Supports Total:						21937.00
Electronic Home-based Supports	service	10	2.00	1096.85	21937.00	
Employment and community transportation Total:						2182.24
Rides 10 miles and under	trip	1	451.00	2.74	1235.74	
Rides 10-20 miles	trip	1	350.00	1.05	367.50	
Rides over 20 miles	trip	1	300.00	0.99	297.00	
Public transportation	trip	1	300.00	0.94	282.00	
Environmental Modifications Total:						4789.79
Environmental Modifications	service	1	1.00	4789.79	4789.79	
Group Supported Employment Total:						178375.26
Group Supported Employment	hour	21	478.00	17.77	178375.26	
Peer Mentor Supports Total:						122.35
Peer Mentor Supports	hour	1	5.00	24.47	122.35	
Personal Emergency Response System (PERS) Total:						35.05
Personal Emergency Response System (PERS)	service	1	1.00	35.05	35.05	
Shared Living Total:						11227.37
Shared Living	month	1	11.00	1020.67	11227.37	
Transition Services Total:						100.00
Transition Services	service	1	1.00	100.00	100.00	
				GRAND TOTAL:		8659882.08
				Total Estimated Unduplicated Participants:		397
				Factor D (Divide total by number of participants):		21813.30
				Average Length of Stay on the Waiver:		327

Appendix J: Cost Neutrality 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:						2463386.78
Group Day Services	hour	194	743.00	17.09	2463386.78	
Independent Living Supports Total:						4141926.88
Independent Living Supports	month	196	13.00	1625.56	4141926.88	
Individual Supported Employment Total:						946621.13
Individual Supported Employment	hour	91	167.00	62.29	946621.13	
Assistive Technology Total:						27131.76
Assistive Technology	service	9	2.00	1507.32	27131.76	
Benefits Planning Total:						7922.60
Benefits Planning	hour	14	10.00	56.59	7922.60	
Center-based Crisis Supports Total:						123145.22
Crisis Supervision	hour	5	89.00	24.84	11053.80	
Crisis Intervention	month	7	161.00	99.46	112091.42	
Community Coaching Total:						25752.00
Community Coaching	hour	3	200.00	42.92	25752.00	
Community Engagement Total:						689240.76
Community Engagement	hour	78	362.00	24.41	689240.76	
Community Guide Total:						61288.50
Community Guide	hour	21	50.00	58.37	61288.50	
Community-based Crisis Supports Total:						6300.65
Crisis Intervention	hour	5	11.00	108.91	5990.05	
Crisis Supervision	hour	1	10.00	31.06	310.60	
				GRAND TOTAL:		8715144.78
				Total Estimated Unduplicated Participants:		399
				Factor D (Divide total by number of participants):		21842.47
				Average Length of Stay on the Waiver:		327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Support Services Total:						**1465.74**
Crisis Supervision	hour	1	3.00	31.06	**93.18**	
Crisis Intervention	hour	4	3.00	114.38	**1372.56**	
Electronic Home-based Supports Total:						**24130.70**
Electronic Home-based Supports	service	11	2.00	1096.85	**24130.70**	
Employment and community transportation Total:						**2182.24**
Rides 10 miles and under	trip	1	451.00	2.74	**1235.74**	
Rides 10-20 miles	trip	1	350.00	1.05	**367.50**	
Rides over 20 miles	trip	1	300.00	0.99	**297.00**	
Public transportation	trip	1	300.00	0.94	**282.00**	
Environmental Modifications Total:						**4789.79**
Environmental Modifications	service	1	1.00	4789.79	**4789.79**	
Group Supported Employment Total:						**178375.26**
Group Supported Employment	hour	21	478.00	17.77	**178375.26**	
Peer Mentor Supports Total:						**122.35**
Peer Mentor Supports	hour	1	5.00	24.47	**122.35**	
Personal Emergency Response System (PERS) Total:						**35.05**
Personal Emergency Response System (PERS)	service	1	1.00	35.05	**35.05**	
Shared Living Total:						**11227.37**
Shared Living	month	1	11.00	1020.67	**11227.37**	
Transition Services Total:						**100.00**
Transition Services	service	1	1.00	100.00	**100.00**	

GRAND TOTAL:	**8715144.78**
Total Estimated Unduplicated Participants:	**399**
Factor D (Divide total by number of participants):	**21842.47**
Average Length of Stay on the Waiver:	327

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:						2463386.78
Group Day Services	hour	194	743.00	17.09	2463386.78	
Independent Living Supports Total:						4163059.16
Independent Living Supports	month	197	13.00	1625.56	4163059.16	
Individual Supported Employment Total:						946621.13
Individual Supported Employment	hour	91	167.00	62.29	946621.13	
Assistive Technology Total:						27131.76
Assistive Technology	service	9	2.00	1507.32	27131.76	
Benefits Planning Total:						8488.50
Benefits Planning	hour	15	10.00	56.59	8488.50	
Center-based Crisis Supports Total:						123145.22
Crisis Supervision	hour	5	89.00	24.84	11053.80	
Crisis Intervention	hour	7	161.00	99.46	112091.42	
Community Coaching Total:						25752.00
Community Coaching	hour	3	200.00	42.92	25752.00	
Community Engagement Total:						689240.76
Community Engagement	hour	78	362.00	24.41	689240.76	
Community Guide Total:						61288.50
Community Guide	hour	21	50.00	58.37	61288.50	
Community-based Crisis Supports Total:						6300.65

GRAND TOTAL:	8736842.96
Total Estimated Unduplicated Participants:	400
Factor D (Divide total by number of participants):	21842.11
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Intervention	hour	5	11.00	108.91	5990.05	
Crisis Supervision	hour	1	10.00	31.06	310.60	
Crisis Support Services Total:						1465.74
Crisis Supervision	hour	1	3.00	31.06	93.18	
Crisis Intervention	hour	4	3.00	114.38	1372.56	
Electronic Home-based Supports Total:						24130.70
Electronic Home-based Supports	service	11	2.00	1096.85	24130.70	
Employment and community transportation Total:						2182.24
Rides 10 miles and under	trip	1	451.00	2.74	1235.74	
Rides 10-20 miles	trip	1	350.00	1.05	367.50	
Rides over 20 miles	trip	1	300.00	0.99	297.00	
Public transportation	trip	1	300.00	0.94	282.00	
Environmental Modifications Total:						4789.79
Environmental Modifications	service	1	1.00	4789.79	4789.79	
Group Supported Employment Total:						178375.26
Group Supported Employment	hour	21	478.00	17.77	178375.26	
Peer Mentor Supports Total:						122.35
Peer Mentor Supports	hour	1	5.00	24.47	122.35	
Personal Emergency Response System (PERS) Total:						35.05
Personal Emergency Response System (PERS)	service	1	1.00	35.05	35.05	
Shared Living Total:						11227.37
Shared Living	month	1	11.00	1020.67	11227.37	
Transition Services Total:						100.00
Transition Services					100.00	

GRAND TOTAL:	8736842.96
Total Estimated Unduplicated Participants:	400
Factor D (Divide total by number of participants):	21842.11
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	service	1	1.00	100.00		
		GRAND TOTAL:				8736842.96
		Total Estimated Unduplicated Participants:				400
		Factor D (Divide total by number of participants):				21842.11
		Average Length of Stay on the Waiver:				327