



VIRGINIA

REGISTER OF REGULATIONS

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VIRGINIA REGISTER INFORMATION PAGE

THE VIRGINIA REGISTER OF REGULATIONS is an official state publication issued every other week throughout the year. Indexes are published quarterly, and are cumulative for the year. The *Virginia Register* has several functions. The new and amended sections of regulations, both as proposed and as finally adopted, are required by law to be published in the *Virginia Register*. In addition, the *Virginia Register* is a source of other information about state government, including petitions for rulemaking, emergency regulations, executive orders issued by the Governor, and notices of public hearings on regulations.

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

An agency wishing to adopt, amend, or repeal regulations must first publish in the *Virginia Register* a notice of intended regulatory action; a basis, purpose, substance and issues statement; an economic impact analysis prepared by the Department of Planning and Budget; the agency's response to the economic impact analysis; a summary; a notice giving the public an opportunity to comment on the proposal; and the text of the proposed regulation.

Following publication of the proposal in the *Virginia Register*, the promulgating agency receives public comments for a minimum of 60 days. The Governor reviews the proposed regulation to determine if it is necessary to protect the public health, safety and welfare, and if it is clearly written and easily understandable. If the Governor chooses to comment on the proposed regulation, his comments must be transmitted to the agency and the Registrar no later than 15 days following the completion of the 60-day public comment period. The Governor's comments, if any, will be published in the *Virginia Register*. Not less than 15 days following the completion of the 60-day public comment period, the agency may adopt the proposed regulation.

The Joint Commission on Administrative Rules (JCAR) or the appropriate standing committee of each house of the General Assembly may meet during the promulgation or final adoption process and file an objection with the Registrar and the promulgating agency. The objection will be published in the *Virginia Register*. Within 21 days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative body, and the Governor.

When final action is taken, the agency again publishes the text of the regulation as adopted, highlighting all changes made to the proposed regulation and explaining any substantial changes made since publication of the proposal. A 30-day final adoption period begins upon final publication in the *Virginia Register*.

The Governor may review the final regulation during this time and, if he objects, forward his objection to the Registrar and the agency. In addition to or in lieu of filing a formal objection, the Governor may suspend the effective date of a portion or all of a regulation until the end of the next regular General Assembly session by issuing a directive signed by a majority of the members of the appropriate legislative body and the Governor. The Governor's objection or suspension of the regulation, or both, will be published in the *Virginia Register*. If the Governor finds that changes made to the proposed regulation have substantial impact, he may require the agency to provide an additional 30-day public comment period on the changes. Notice of the additional public comment period required by the Governor will be published in the *Virginia Register*.

The agency shall suspend the regulatory process for 30 days when it receives requests from 25 or more individuals to solicit additional public comment, unless the agency determines that the changes have minor or inconsequential impact.

A regulation becomes effective at the conclusion of the 30-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 21-day objection period; (ii) the Governor exercises his authority to require the agency to provide for additional public comment, in which event the regulation,

unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period and no earlier than 15 days from publication of the readopted action.

A regulatory action may be withdrawn by the promulgating agency at any time before the regulation becomes final.

FAST-TRACK RULEMAKING PROCESS

Section 2.2-4012.1 of the Code of Virginia provides an exemption from certain provisions of the Administrative Process Act for agency regulations deemed by the Governor to be noncontroversial. To use this process, Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations will become effective on the date noted in the regulatory action if no objections to using the process are filed in accordance with § 2.2-4012.1.

EMERGENCY REGULATIONS

Pursuant to § 2.2-4011 of the Code of Virginia, an agency, upon consultation with the Attorney General, and at the discretion of the Governor, may adopt emergency regulations that are necessitated by an emergency situation. An agency may also adopt an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited to no more than 18 months in duration; however, may be extended for six months under certain circumstances as provided for in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Register*. During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures. To begin promulgating the replacement regulation, the agency must (i) file the Notice of Intended Regulatory Action with the Registrar within 60 days of the effective date of the emergency regulation and (ii) file the proposed regulation with the Registrar within 180 days of the effective date of the emergency regulation. If the agency chooses not to adopt the regulations, the emergency status ends when the prescribed time limit expires.

STATEMENT

The foregoing constitutes a generalized statement of the procedures to be followed. For specific statutory language, it is suggested that Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2 of the Code of Virginia be examined carefully.

CITATION TO THE VIRGINIA REGISTER

The *Virginia Register* is cited by volume, issue, page number, and date. **29:5 VA.R. 1075-1192 November 5, 2012**, refers to Volume 29, Issue 5, pages 1075 through 1192 of the *Virginia Register* issued on November 5, 2012.

The Virginia Register of Regulations is published pursuant to Article 6 (§ 2.2-4031 et seq.) of Chapter 40 of Title 2.2 of the Code of Virginia.

Members of the Virginia Code Commission: **John S. Edwards**, Chair; **James M. LeMunyon**, Vice Chair; **Gregory D. Habeeb**; **Ryan T. McDougle**; **Robert L. Calhoun**; **Carlos L. Hopkins**; **Leslie L. Lilley**; **E.M. Miller, Jr.**; **Thomas M. Moncure, Jr.**; **Christopher R. Nolen**; **Timothy Oksman**; **Charles S. Sharp**; **Mark J. Vucci**.

Staff of the Virginia Register: **Jane D. Chaffin**, Registrar of Regulations; **Karen Perrine**, Assistant Registrar; **Anne Bloomsburg**, Regulations Analyst; **Rhonda Dyer**, Publications Assistant; **Terri Edwards**, Operations Staff Assistant.

PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the *Register's* Internet home page (<http://register.dls.virginia.gov>).

September 2016 through August 2017

<u>Volume: Issue</u>	<u>Material Submitted By Noon*</u>	<u>Will Be Published On</u>
33:2	August 31, 2016	September 19, 2016
33:3	September 14, 2016	October 3, 2016
33:4	September 28, 2016	October 17, 2016
33:5	October 12, 2016	October 31, 2016
33:6	October 26, 2016	November 14, 2016
33:7	November 9, 2016	November 28, 2016
33:8	November 22, 2016 (Tuesday)	December 12, 2016
33:9	December 7, 2016	December 26, 2016
33:10	December 19, 2016 (Monday)	January 9, 2017
33:11	January 4, 2017	January 23, 2017
33:12	January 18, 2017	February 6, 2017
33:13	February 1, 2017	February 20, 2017
33:14	February 15, 2017	March 6, 2017
33:15	March 1, 2017	March 20, 2017
33:16	March 15, 2017	April 3, 2017
33:17	March 29, 2017	April 17, 2017
33:18	April 12, 2017	May 1, 2017
33:19	April 26, 2017	May 15, 2017
33:20	May 10, 2017	May 29, 2017
33:21	May 24, 2017	June 12, 2017
33:22	June 7, 2017	June 26, 2017
33:23	June 21, 2017	July 10, 2017
33:24	July 5, 2017	July 24, 2017
33:25	July 19, 2017	August 7, 2014
33:26	August 2, 2017	August 21, 2017

*Filing deadlines are Wednesdays unless otherwise specified.

PETITIONS FOR RULEMAKING

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Initial Agency Notice

Title of Regulation: **18VAC60-21. Regulations Governing the Practice of Dentistry.**

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Name of Petitioner: Dr. Christine Barry.

Nature of Petitioner's Request: To add to the listing of approved providers of continuing education, "and other continuing education organizations as approved by the Board."

Agency Plan for Disposition of Request: The petition will be published on September 19, 2016, in the Virginia Register of Regulations and also posted on the Virginia Regulatory Town Hall at www.townhall.virginia.gov to receive public comment ending October 19, 2016. The request to amend regulations and any comments for or against the petition will be considered by the board at its meeting scheduled for December 9, 2016.

Public Comment Deadline: October 19, 2016.

Agency Contact: Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, or email elaine.yeatts@dhp.virginia.gov.

V.A.R. Doc. No. R17-01; Filed August 25, 2016, 8:45 a.m.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health intends to consider amending **12VAC5-90, Regulations for Disease Reporting and Control** and promulgating **12VAC5-101, Virginia Cancer Reporting Regulation**. The purpose of the proposed action is to remove provisions related to the Virginia Cancer Registry from 12VAC5-90, the Regulations for Disease Reporting and Control, and establish a separate chapter for the Virginia Cancer Registry in 12VAC5-101 to reflect the organizational structure and operating procedures of the Department of Health and update and clarify the regulation. Changes being considered include (i) clarifying when physicians are required to report, (ii) clarifying when a report will be rejected, (iii) requiring electronic reporting, and (iii) addressing the department's actions when a required reporter does not report.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 32.1-12 and 32.1-35 of the Code of Virginia.

Public Comment Deadline: October 19, 2016.

Agency Contact: Susan Puglisi, Policy Analyst, Office of Family Health Services, Virginia Department of Health, 109 Governor Street, 10th Floor, Richmond, VA 23219, telephone (804) 864-7175, FAX (804) 864-7647, or email susan.puglisi@vdh.virginia.gov.

VA.R. Doc. No. R17-4857; Filed August 19, 2016, 3:19 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health intends to consider amending **12VAC5-490, Virginia Radiation Protection Regulations: Fee Schedule**. The purpose of the proposed action is to establish (i) a fee for the registration of an individual who inspects x-ray devices in the Commonwealth and (ii) an application change fee for the modification of an inspector's certificate each time an addition or change is requested by that individual.

In addition, this regulation will undergo a periodic review pursuant to Executive Order 17 (2014) and a small business impact review pursuant to § 2.2-4007.1 of the Code of Virginia to determine whether this regulation should be terminated, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small

businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 32.1-229.1 of the Code of Virginia.

Public Comment Deadline: October 19, 2016.

Agency Contact: Steve Harrison, Director, Division of Radiological Health, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-8151, FAX (804) 864-8155, or email steve.harrison@vdh.virginia.gov.

VA.R. Doc. No. R17-4856; Filed August 19, 2016, 3:08 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Medical Assistance Services intends to consider amending:

12VAC30-50, Amount, Duration, and Scope of Medical and Remedial Care Services;

12VAC30-60, Standards Established and Methods Used to Assure High Quality Care;

12VAC30-80, Methods and Standards for Establishing Payment Rates; Other Types of Care; and

12VAC30-120, Waivered Services.

The purpose of the proposed action is to redesign three of the department's existing home-based and community-based waivers as follows: the Individual and Family Developmental Disabilities Support Waiver (12VAC30-120-700 et seq.) becomes the Family and Individual Supports Waiver, the Intellectual Disability Waiver (12VAC30-120-1000 et seq.) becomes the Community Living Waiver, and the Day Support Waiver for Individuals with Mental Retardation (12VAC30-120-1500 et seq.) becomes the Building Independence Waiver.

The proposed redesign is intended to (i) better support individuals with disabilities to live integrated and engaged lives in their communities; (ii) standardize and simplify access to services; (iii) cover services that promote community integration and engagement; (iv) improve providers' capacity and quality by increasing compensation as they increase expertise; (v) achieve better outcomes for individuals supported in smaller community settings; (vi) facilitate meeting the Commonwealth's commitments under the community integration mandate of the American with Disabilities Act (42 USC § 12101 et seq.), the United States Supreme Court's decision in *Olmstead v. L.C.*, and the 2012 U.S. Department of Justice Settlement Agreement; and (vii) make technical and clarifying changes.

Notices of Intended Regulatory Action

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396.

Public Comment Deadline: October 24, 2016.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

V.A.R. Doc. No. R17-4614; Filed August 24, 2016, 11:15 a.m.

REGULATIONS

For information concerning the different types of regulations, see the Information Page.

Symbol Key

Roman type indicates existing text of regulations. Underscored language indicates proposed new text. Language that has been stricken indicates proposed text for deletion. Brackets are used in final regulations to indicate changes from the proposed regulation.

TITLE 2. AGRICULTURE

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Final Regulation

REGISTRAR'S NOTICE: The Department of Agriculture and Consumer Services is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 A 13 of the Code of Virginia, which excludes the Commissioner and the Board of Agriculture and Consumer Services when promulgating regulations pursuant to § 3.2-5406 of the Code of Virginia including adopting (i) by reference any regulation under the federal acts as it pertains to Chapter 54 (§ 3.2-5400 et seq.) of Title 3.2 of the Code of Virginia, amending it as necessary for intrastate applicability and (ii) any regulation containing provisions no less stringent than those contained in federal regulation. The Department of Agriculture and Consumer Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 2VAC5-210. Rules and Regulations Pertaining to Meat and Poultry Inspection under the Virginia Meat and Poultry Products Inspection Act (amending 2VAC5-210-10).

Statutory Authority: § 3.2-5406 of the Code of Virginia.

Effective Date: August 31, 2016.

Agency Contact: Barry Jones, Program Manager, Meat and Poultry Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-4569, FAX (804) 786-1003, TTY (800) 828-1120, or email barry.jones@vdacs.virginia.gov.

Summary:

The amendment updates the publication date for Title 9, Chapter III, Subchapters A and E of the Code of Federal Regulations (CFR) referenced in this regulation from January 1, 2013, to January 1, 2016. The U.S. Department of Agriculture/Food Safety and Inspection Service (USDA/FSIS) amended sections of these subchapters of the CFR after 2VAC5-210 was last amended. The USDA/FSIS revisions to the CFR that are incorporated by reference include (i) removal of prescriptive time and temperature parameters for ready-to-cook poultry and the requirement that poultry establishments, other than ratite establishments, incorporate procedures for chilling poultry into their hazard analysis and critical control point plan or sanitation standard operating procedures or other

*prerequisite programs; (ii) a requirement that official poultry slaughter establishments develop, implement, and maintain written procedures to prevent contamination of carcasses and parts by enteric pathogens and fecal contamination throughout the entire slaughter and dressing operation, and that establishments maintain daily records to document the implementation and monitoring of these procedures; (iii) clarifying that establishments may not release into commerce product that has been in contact with *Listeria monocytogenes*-contaminated surfaces without reprocessing the product; (iv) a requirement that a descriptive designation be used as part of the product name on the labels of raw meat and poultry products that contain added solutions and that do not meet a standard of identity; (v) a requirement that the product name for mechanically tenderized beef contain the descriptive designation "mechanically tenderized," "needle tenderized," or "blade tenderized" and that labels of raw or partially cooked needle-tenderized or blade-tenderized raw beef products destined for household consumers, hotels, restaurants, or similar institutions bear validated cooking instructions.*

Part I

Adoption by Reference

2VAC5-210-10. Adoption by reference.

The rules and regulations governing the meat and poultry inspection of the United States Department of Agriculture specified in this part, as contained in Title 9, Chapter III, Subchapters A and E of the Code of Federal Regulations, as it exists and has been published in the January 1, ~~2013~~ 2016, update with amendments and with administrative changes therein as needed to make them appropriate and applicable to intrastate operations and transactions subject to the Virginia Meat and Poultry Products Inspection Act, are hereby adopted by reference.

VA.R. Doc. No. R17-4805; Filed August 31, 2016, 11:15 a.m.

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Final Regulation

REGISTRAR'S NOTICE: Section 3.2-4411.1 of the Code of Virginia provides that initial regulations adopted by the Board of Agriculture and Consumer Services to implement the section are exempt from Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act provided the board publishes proposed regulations in the Virginia Register of Regulations and allows at least 30 days for public comment, to include an online public comment forum on the Virginia Regulatory Town Hall, after publication.

Title of Regulation: 2VAC5-319. Best Management Practices for the Operation of Apiaries in Order to Limit Operator Liability (adding 2VAC5-319-10 through 2VAC5-319-30).

Statutory Authority: § 3.2-4411.1 of the Code of Virginia.

Effective Date: August 31, 2016.

Agency Contact: Debra Martin, Program Manager, Office of Plant Industry Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-3515, FAX (804) 371-7793, or email debra.martin@vdacs.virginia.gov.

Summary:

Section 3.2-4411.1 of the Code of Virginia provides that a beekeeper shall not be liable for any personal injury or property damage that occurs in connection with his keeping and maintaining of bees, bee equipment, queen breeding equipment, apiaries, or appliances if he follows best management practices established in regulations adopted by the Board of Agriculture and Consumer Services. A person is not required to comply with the provisions of the regulation unless he seeks to limit his liability as provided for in § 3.2-4411.1.

The best management practices established in the regulation direct apiary operators to comply with local, state, and federal ordinances, regulations, and laws pertaining to beekeeping. The best management practices further direct apiary operators keeping honey bees to (i) maintain a healthy populous colony of bees, (ii) provide or maintain adequate honey and pollen as food stores for winter survival, (iii) practice management and control techniques to reduce the likelihood of swarming, (iv) maintain colonies at least 10 feet away from property lines and place all colonies that are less than 40 feet from a property line behind a barrier that is no less than six feet high or elevate the hive entrance to no less than six feet above the property line, (v) maintain a water source within 50 feet of a colony or less than one-half the distance to the nearest unnatural source of water when the operator expects that his bees will rely on a nearby unnatural source of water, (vi) avoid opening or disturbing a colony when the operator is aware of other persons in the vicinity, (vii) only maintain a colony with European honey bees (EHB) or EHB hybrid stock, and (viii) limit the number of colonies placed on his property based upon the maximum number of colonies allowed per acre or portion of an acre as established in the regulation.

**CHAPTER 319
BEST MANAGEMENT PRACTICES FOR THE
OPERATION OF APIARIES IN ORDER TO LIMIT
OPERATOR LIABILITY**

2VAC5-319-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Apiary" means any place where one or more colonies of bees are kept.

"Apiary operator" means a person who operates an apiary and seeks to limit his liability for any personal injury or property damage that occurs in connection with his keeping and maintaining of bees, bee equipment, queen breeding equipment, apiaries, or appliances as provided for in § 3.2-4411.1 of the Code of Virginia.

"Bee" means the honey bee, *Apis mellifera* and genetic variations thereof, at any living stage and may include other hymenopterous insects that depend on pollen and nectar for food.

"Bee equipment" means hives [~~and~~] hive parts [,] including frames, supers, covers, [and] bottom boards [;] and beekeeping apparel.

"Colony" means a queenright assemblage of social bees capable of reproducing.

"Comb" means a mass of six-sided cells used by honey bees in which brood is reared and honey and pollen are stored.

"Disease" means departure from a sound state of health of bees characterized by visible symptoms including American foulbrood and any other diseases, insects, mites, or bee pests.

"Division" means to separate a bee colony into two or more hives.

"EHB" mean European honey bees.

"Foundation" means a template, base, or midrib used for the production of straight, movable comb in a frame.

"Frame" means a wooden or plastic form, usually consisting of four sides, designed to hold comb spaced between 1/4 inch and 3/8 inch apart and to allow for removal of the frame without damage to the comb.

"Hive" means a box, skep, barrel, log gum, or other container used as a domicile for bees.

"Split" means a division of a bee colony for the purposes of increasing the number of hives.

"Swarm" or "swarming" means a form of propagation of bees in which all or a portion of a colony, usually containing at least one queen, departs from its original hive to establish a new colony.

2VAC5-319-20. Limitation of liability.

A. An apiary operator operating in conformance with § 3.2-4411.1 of the Code of Virginia and this chapter shall not be liable for any personal injury or property damage that occurs

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in connection with his keeping and maintaining of bees, bee equipment, queen breeding equipment, apiaries, or appliances. This limitation of liability does not apply to intentional tortious conduct or acts or omissions constituting gross negligence or negligence.

B. A person is not required to comply with the provisions of this chapter unless he seeks to limit his liability as provided for in § 3.2-4411.1 of the Code of Virginia.

[2VAC5-319-25. Best management practices.

An apiary operator shall comply with local, state, and federal ordinances, regulations, and laws pertaining to beekeeping. This section shall apply to an apiary operator keeping any honey bee, *Apis mellifera* and genetic variations thereof, at any living stage, or other hymenopterous insect that depends on pollen and nectar for food.]

2VAC5-319-30. Best management practices [for the keeping of honey bees]:

A. [~~An apiary operator shall comply with local, state, and federal ordinances, regulations, and laws pertaining to beekeeping~~ For the purpose of this section, "bee" means the honey bee, *Apis mellifera* and genetic variations thereof, at any living stage, and does not mean other hymenopterous insects that depend on pollen and nectar for food].

B. An apiary operator shall maintain a healthy populous colony of bees by:

1. ~~Removing or securely sealing any empty bee equipment in an apiary. For the purpose of this subdivision, "empty" means without bees but containing comb or other materials attractive to bees [and does not include equipment in use as a bait hive for capturing a swarm];~~

2. ~~Removing all colonies in a state of decline [or,] combining such colonies with other colonies [, or taking other action to establish a healthy populous condition in such colonies];~~

3. ~~Repairing or replacing [old, worn, damaged] or defective hive boxes, frames, and other bee equipment;~~

4. ~~Replacing frames containing old comb with new or cleaned frames containing foundation such that all comb in a hive is replaced every five to seven years;~~

5. [~~Maintaining a minimum of 20 pounds~~ Feeding or maintaining an adequate amount] of honey [and pollen] in a hive [~~with the equivalent of one frame of pollen stores~~] for brood production during the growing season;

6. Preventing disturbance or injury to bee colony or hive by vertebrate pests; and

7. [~~Monitoring disease and pest levels to ensure that treatment thresholds are not exceeded. An apiary operator shall manage~~ Managing] the colony to address any disease or pest infestation or remove all disease or pest-infested hives that may be detrimental to the health of other colonies in the vicinity of the apiary. An apiary operator

shall inspect hives for disease at least once every three months.

C. For the purposes of this subsection, (i) "full hive" means a hive consisting of a minimum of two eight-frame deep hive boxes for a Langstroth-style hive, or a hive of equivalent capacity, that has movable frames with combs, and (ii) "nucleus hive" means a hive with less capacity than a full hive. A full hive should enter the winter with a minimum of 60 pounds of honey and the equivalent of four frames of pollen stores. A nucleus hive should enter the winter with a minimum of 30 pounds of honey and the equivalent of two frames of pollen stores.

D. An apiary operator shall practice proper management and control techniques to reduce the likelihood of swarming.

E. An apiary operator shall maintain all colonies at least 10 feet away from property lines to prevent an individual from impeding normal bee flight activity from a hive. An apiary operator shall place all colonies that are less than 40 feet from a property line behind a barrier that is no less than six feet in height and is located between the colony and the property line [or elevate the hive entrance no less than six feet above the property line]. Barriers should be of sufficient density, length, and height to establish bee flyways six feet or higher above ground level.

F. [~~An~~ When an apiary is located in an area in which the apiary operator should reasonably expect that the bees may rely on a nearby unnatural source of water, the] apiary operator shall maintain a water source within 50 feet of a colony or less than one-half the distance to the nearest unnatural [~~water~~] source [of water], whichever is closest. An unnatural [~~water~~] source [of water] includes a swimming pool, bird bath, and pet or livestock watering receptacle.

[~~G. An apiary operator shall not maintain an apiary within 50 feet of any animal that is tethered, kenneled, or otherwise prevented from escaping a possible stinging incident.~~

H. G.] An apiary operator shall avoid opening or disturbing a colony when [the apiary operator has knowledge that] another person is participating in outside non-beekeeping activities or using machinery within 150 feet of the apiary.

[~~I. H.~~] An apiary operator shall only maintain a colony with EHB or EHB hybrid stock and shall:

1. [~~Obtain~~ Purchase] queens, packaged bees, nucleus colonies, or established hives from suppliers providing EHB stock, or obtain a queen and bees from a local supplier [or raise queens from stock owned by the apiary operator, provided the origin and EHB status of the mother queen is known];

2. Not obtain queens or bees from suppliers within 100 miles from known Africanized honey bee populations;

3. Introduce queens from healthy stock when making divisions or splits of established colonies;

4. Replace queens in all captured or trapped swarms within [30 45] days of capturing or trapping swarms;

5. Replace queens in all colonies every two years to minimize swarming behavior; and

6. Mark the thorax or clip a wing of the queens [in a manner that allows the age of the queens to be determined] prior to their introduction to splits, swarms, [and or] colonies.

[I. An apiary operator shall limit the number of colonies that he places in his apiary as follows:

1. If the property on which the apiary is located is 1/4 acre or smaller, the apiary shall not have more than two colonies. The apiary operator may increase the number of colonies up to four colonies for not more than 60 consecutive days for the purpose of queen mating and swarm control.

2. If the property on which the apiary is located is more than 1/4 acre, but less than 1/2 acre, the apiary shall not have more than four colonies. The apiary operator may increase the number of colonies up to eight colonies for not more than 60 consecutive days for the purpose of queen mating and swarm control.

3. If the property on which the apiary is located is 1/2 acre or more, but less than one acre, the apiary shall not have more than six colonies. The apiary operator may increase the number of colonies up to 12 colonies for not more than 60 consecutive days for the purpose of queen mating and swarm control.

4. If the property on which the apiary is located is one acre or more, the apiary shall not have more than six colonies per acre. The apiary operator may increase the number of colonies up to 12 colonies per acre for not more than 60 consecutive days for the purpose of queen mating and swarm control.

5. If all colonies are placed at least 200 feet from all property lines, there is no limit on the number of colonies that an apiary operator may place in his apiary.]

VA.R. Doc. No. R16-4712; Filed August 31, 2016, 11:24 a.m.

◆ ————— ◆
TITLE 4. CONSERVATION AND NATURAL RESOURCES

BOARD OF GAME AND INLAND FISHERIES

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: 4VAC15-260. Game: Waterfowl and Waterfowl Blinds (adding 4VAC15-260-75).

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: August 31, 2016.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 7870 Villa Park Drive, Suite 400, Henrico, VA 23228, telephone (804) 367-8341, or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) prohibit the licensing of nonriparian stationary waterfowl blinds adjacent to the Ware Creek Wildlife Management Area and (ii) enable the department to designate the locations where and the times when waterfowl hunting will be allowed within 500 yards of the wildlife management area.

4VAC15-260-75. Blinds adjacent to the Ware Creek Wildlife Management Area.

Except for blinds built or maintained by the department, no stationary waterfowl blinds shall be licensed on the public waters of Philbates and Ware Creeks, or on the York River within 1000 yards of the Ware Creek Wildlife Management Area [~~in New Kent County~~]. Waterfowl hunting within 500 yards of the wildlife management area property will be permitted only at locations and during times designated by the department. However, this section shall not abridge the privileges prescribed for landowners and their lessees and permittees in §§ 29.1-344 and 29.1-347 of the Code of Virginia.

VA.R. Doc. No. R16-4803; Filed August 19, 2016, 1:28 p.m.

MARINE RESOURCES COMMISSION

Final Regulation

REGISTRAR'S NOTICE: The Marine Resources Commission is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 11 of the Code of Virginia; however, the commission is required to publish the full text of final regulations.

Title of Regulation: 4VAC20-260. Pertaining to Designation of Seed Areas and Clean Cull Areas (amending 4VAC20-260-15, 4VAC20-260-50).

Statutory Authority: § 28.2-201 of the Code of Virginia.

Effective Date: September 1, 2016.

Agency Contact: Alicia Nelson, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-8155, or email alicia.nelson@mrc.virginia.gov.

Summary:

The amendments redefine "basket" and establish the basket filled level across the entire top as the only unit of

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measurement for buying or selling clean cull oysters harvested from oyster grounds.

4VAC20-260-15. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Basket" means a circular plastic mesh container of ~~not less than 2,500~~ 2,566 cubic inches ~~but not more than 3,000 cubic inches,~~ with a top inside diameter of 17 inches, bottom inside diameter of 13.5 inches, and an inside height of 14 inches that may be used for the measurement of oysters to be sold or purchased.

"Clean culled oyster" means any oyster taken from natural public beds, rocks, or shoals that is three inches or greater in shell length.

"Level full" means a basket or tub that is filled entirely to the upper rim, but not filled higher than the upper rim.

"Oyster" means any shellfish of the species *Crassostrea virginica*.

"Seed oyster" means any oyster taken by any person from natural beds, rocks, or shoals that is more than 30 days from harvest for human consumption.

4VAC20-260-50. Culling and inspection procedures.

A. All oysters taken from natural public beds, rocks, or shoals shall be placed on the culling board, or in only one basket upon the culling board, and culled by hand at the location of harvest.

1. Culled oysters shall be transferred immediately from the culling board to either the inside open part of the boat, a loose pile, or baskets, but only one transfer method may be used on any boat or vessel in any one day.

a. Oysters shall not be stored in both a loose pile and in baskets.

b. A single basket may be on board any boat during transfer of culled oysters from the culling board to the inside open part of the boat in a loose pile.

2. The entire harvest shall be subject to inspection, as provided in subsection F of this section.

B. Any oysters taken lawfully by hand from natural public beds, rocks, or shoals from the seaside of the Eastern Shore, and held in sacks, bags, or containers, shall be culled when taken and placed in those sacks, bags, or containers for inspection by any police officer as described in subsection G of this section.

C. If oysters from leased grounds and oysters from public grounds are mixed in the same cargo on a boat or motor vehicle, the entire cargo shall be subject to inspection under this chapter.

D. It shall be unlawful for any person to buy, sell, or report clean cull oysters by any measure other than as those described in § 28.2-526 A of the Code of Virginia, ~~or the~~

~~alternate container described in subsection E of this section; except that on the seaside of the Eastern Shore oysters may be sold without being measured if both the buyer and the seller agree to the number of bushels of oysters in the transaction filled to level full. The container described in § 28.2-526 A 2 is a basket.~~ It shall be unlawful for any person to sell, purchase, or report the sale or purchase of any clean cull oysters harvested from public grounds, as described in 4VAC20-720-40, in excess of the harvest limits described in 4VAC20-720-80.

~~E. An alternate container produced by North Machine Shop in Mathews, Virginia, may be used for measuring oysters to be sold or purchased. The dimensions of this metallic cylindrical container shall be 18.5 inches inside diameter and 11 inches inside height. It shall be unlawful for any person to buy, sell, or report seed oysters by any measure other than as described in § 28.2-526 of the Code of Virginia.~~

F. Oysters may be inspected by any police officer according to any one of the following provisions:

1. For any oysters transferred from the culling board to the inside open part of the boat, vehicle, or trailer or a loose pile, any police officer may use a shovel to take at least one bushel of oysters to inspect, at random, provided that the entire bushel or basket shall be taken from one place in the open pile of oysters.

2. For any oysters transferred from a vessel to a motor vehicle or trailer, any police officer may select one or more baskets of oysters and empty the contents of those baskets into a bushel or basket, as described in § 28.2-526 of the Code of Virginia, for inspection.

G. In the inspection of oysters harvested by hand from waters of the seaside of the Eastern Shore, the police officer may select any sacks, bags, or containers at random to establish a full metallic measuring bushel or basket for purposes of inspection.

H. On the seaside of the Eastern Shore oysters may be sold without being measured if both the buyer and the seller agree to the number of bushels of oysters in the transaction.

V.A.R. Doc. No. R17-4826; Filed August 25, 2016, 2:36 p.m.

Final Regulation

<p>REGISTRAR'S NOTICE: The Marine Resources Commission is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 11 of the Code of Virginia; however, the commission is required to publish the full text of final regulations.</p>

Title of Regulation: **4VAC20-450. Pertaining to the Taking of Bluefish (amending 4VAC20-450-30).**

Statutory Authority: § 28.2-201 of the Code of Virginia.

Effective Date: September 1, 2016.

Agency Contact: Alicia Nelson, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport

News, VA 23607, telephone (757) 247-8155, or email alicia.nelson@mrc.virginia.gov.

Summary:

The amendments modify the commercial landings quota for bluefish.

4VAC20-450-30. Commercial landings quota.

A. The ~~annual~~ commercial landings of bluefish shall be limited to ~~608,230~~ 580,287 pounds during the current calendar year.

B. When it is projected that 95% of the commercial landings quota has been realized, a notice will be posted to close commercial harvest and landings from the bluefish fishery within five days of posting.

C. It shall be unlawful for any person to harvest or land bluefish for commercial purposes after the closure date set forth in the notice described in subsection B of this section.

VA.R. Doc. No. R17-4867; Filed August 25, 2016, 3:57 p.m.

Final Regulation

REGISTRAR'S NOTICE: The Marine Resources Commission is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 11 of the Code of Virginia; however, the commission is required to publish the full text of final regulations.

Title of Regulation: **4VAC20-720. Pertaining to Restrictions on Oyster Harvest (amending 4VAC20-720-15, 4VAC20-720-20, 4VAC20-720-35 through 4VAC20-720-80).**

Statutory Authority: § 28.2-201 of the Code of Virginia.

Effective Date: August 31, 2016.

Agency Contact: Alicia Nelson, Fisheries Management, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-8155, or email alicia.nelson@mrc.virginia.gov.

Summary:

The amendments establish a license moratorium and transferability requirements of the oyster resource user fee. The amendments also set the open areas and seasons for the upcoming oyster season.

4VAC20-720-15. Control date, license moratorium, transferability, and agents.

A. The commission hereby establishes July 1, 2014, as the control date for management of all public oyster fisheries in Virginia. Participation by any individual in any public oyster fishery after the control date ~~will~~ may not be considered in the calculation or distribution of oyster fishing rights should entry limitations be established. Any individual entering the public oyster fishery after the control date will forfeit any right to future participation in the public oyster fishery should further entry limitations be established by the commission.

B. Beginning February 23, 2016, only individuals who have paid the oyster resource user fee described in clause (ii) of

subsection A of § 28.2-541 of the Code of Virginia in previous years may pay that fee for the current year. Those individuals who are eligible to pay the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia shall do so by April 30, 2017, in 2017 and by January 1 in subsequent years in order to maintain their eligibility.

C. Should the number of people eligible to pay the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia in any given year fall below 600, a random drawing shall be held to award eligibility to pay that oyster resource user fee to individuals who were not previously eligible until the number of persons eligible to pay the fee reaches 600. Any Commercial Fisherman Registration Licensee may apply for the random drawing.

D. Any person eligible to pay the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia may transfer the eligibility to pay such user fee, provided:

1. The transferee is the transferor's spouse, sibling, parent, child, grandparent, or grandchild and possesses a current Commercial Fisherman Registration License and intends to participate in the public oyster fishery.

2. The transferor shall have documented by mandatory reporting and buyers reports 40 days of public oyster harvest during the previous calendar year. All transfers shall be documented on a form provided by Marine Resources Commission.

3. In the case of death or incapacitation, the licensee may transfer such eligibility to an individual who meets the requirements found in subdivision 1 or 2 of this subsection.

E. Exceptions to subsection B of this section shall only apply to those individuals who previously paid the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia and shall be based on documented medical hardships or active military leave that prevented the fisherman from fully satisfying the requirements of subsection B of this section.

F. No person shall serve as an agent for any public oyster gear licensee.

4VAC20-720-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Aid to navigation" means any public or private day beacon, lighted channel marker, channel buoy, lighted channel buoy, or lighthouse that may be at, or adjacent to, any latitude and longitude used in area descriptions.

"Clean culled oyster" means any oyster taken from natural public beds, rocks, or shoals that is three inches or greater in shell length.

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"Coan River Area" means that area of the Coan River inside of Public Grounds 77 and 78 of Northumberland County.

Public Ground 77 of Northumberland County is located near the mouth of the Coan River, beginning at a point approximately 2,300 feet northeast of Honest Point and 1,300 feet southwest of Travis Point, said point being Corner 1, located at Latitude 37° 59.5257207' N., Longitude 76° 27.8810639' W.; thence southwesterly to Corner 2, Latitude 37° 59.3710259' N., Longitude 76° 27.9962148' W.; thence southwesterly to Corner 3, Latitude 37° 59.2953830' N., Longitude 76° 28.0468953' W.; thence northwesterly to Corner 4, Latitude 37° 59.3350863' N., Longitude 76° 28.0968837' W.; thence northeasterly to Corner 5, Latitude 37° 59.3965161' N., Longitude 76° 28.0287342' W.; thence northwesterly to Corner 6, Latitude 37° 59.4758507' N., Longitude 76° 28.1112280' W.; thence north-northwesterly to Corner 7, Latitude 37° 59.5079401' N., Longitude 76° 28.1230058' W.; thence northeasterly to Corner 8, Latitude 37° 59.5579153' N., Longitude 76° 27.9889429' W.; thence southeasterly to Corner 1, said corner being the point of beginning.

Public Ground 78 of Northumberland County is located near the mouth of the Coan River, beginning at a point approximately 3,420 feet southeast of Travis Point and 3,260 feet northwest of Great Point, said point being Corner 1, located at Latitude 37° 59.4822275' N., Longitude 76° 27.1878637' W.; thence southeasterly to Corner 2, Latitude 37° 59.3824046' N., Longitude 76° 27.1088650' W.; thence southwesterly to Corner 3, Latitude 37° 59.2283287' N., Longitude 76° 27.8632901' W.; thence northeasterly to Corner 4, Latitude 37° 59.4368502' N., Longitude 76° 27.6868001' W.; thence continuing northeasterly to Corner 5, Latitude 37° 59.5949216' N., Longitude 76° 27.5399436' W.; thence southeasterly to Corner 1, said corner being the point of beginning.

"Deep Rock Area" means all public grounds and unassigned grounds, in that area of the Chesapeake Bay near Gwynn Island, beginning at Cherry Point at the western-most point of the eastern headland of Kibble Pond located at Latitude 37° 30.9802148' N., Longitude 76° 17.6764393' W.; thence northeasterly to the Piankatank River, Flashing Green Channel Light "3", Latitude 37° 32.3671325' N., Longitude 76° 16.7038334' W.; thence east-southeasterly to the Rappahannock River Entrance Lighted Buoy G"1R", Latitude 37° 32.2712833' N., Longitude 76° 11.4813666' W.; thence southwesterly to the southern-most point of Sandy Point, the northern headland of "The Hole in the Wall", Latitude 37° 28.1475258' N., Longitude 76° 15.8185670' W.; thence northwesterly along the Chesapeake Bay mean low water line of the barrier islands of Milford Haven, connecting headland to headland at their eastern-most points, and of Gwynn Island to the western-most point of the eastern headland of Kibble

Pond on Cherry Point, said point being the point of beginning.

"Deep Water Shoal State Replenishment Seed Area" or "DWS" means that area in the James River near Mulberry Island, beginning at a point approximately 530 feet west of Deep Water Shoal Light, said point being Corner 1, located at Latitude 37° 08.9433287' N., Longitude 76° 38.3213007' W.; thence southeasterly to Corner 2, Latitude 37° 09.5734380' N., Longitude 76° 37.8300582' W.; thence southwesterly to Corner 3, Latitude 37° 08.9265524' N., Longitude 76° 37.0574269' W.; thence westerly to Corner 4, Latitude 37° 08.4466039' N., Longitude 76° 37.4523346' W.; thence northwesterly to Corner 5, Latitude 37° 08.4491489' N., Longitude 76° 38.0215553' W.; thence northeasterly to Corner 1, said corner being the point of beginning.

"Great Wicomico River Area" means all public grounds and unassigned grounds, in that area of the Great Wicomico River, Ingram Bay, and the Chesapeake Bay, beginning at a point on Sandy Point, Latitude 37° 49.3269652' N., Longitude 76° 18.3821766' W.; thence easterly to the southern-most point of Cockrell Point, Latitude 37° 49.2664838' N., Longitude 76° 17.3454434' W.; thence easterly following the mean low water line of Cockrell Point to a point on the boundary of Public Ground 115 at Cash Point, Latitude 37° 49.2695619' N., Longitude 76° 17.2804046' W.; thence southeasterly to the gazebo on the pierhead at Fleets Point, Latitude 37° 48.7855824' N., Longitude 76° 16.9609311' W.; thence southeasterly to the Great Wicomico Lighthouse; thence due south to a point due east of the southern-most point of Dameron Marsh, Latitude 37° 46.6610003' N., Longitude 76° 16.0570007' W.; thence due west to the southern-most point of Dameron Marsh, Latitude 37° 46.6609070' N., Longitude 76° 17.2670707' W.; thence along the mean low water line of Dameron Marsh, north and west to Garden Point, Latitude 37° 47.2519872' N., Longitude 76° 18.4028142' W.; thence northwesterly to Windmill Point, Latitude 37° 47.5194547' N., Longitude 76° 18.7132194' W.; thence northerly along the mean low water to the western headland of Harveys Creek, Latitude 37° 47.7923573' N., Longitude 76° 18.6881450' W.; thence east-southeasterly to the eastern headland of Harveys Creek, Latitude 37° 47.7826936' N., Longitude 76° 18.5469879' W.; thence northerly along the mean low water line, crossing the entrance to Towels Creek at the offshore ends of the jetties and continuing to Bussel Point, Latitude 37° 48.6879208' N., Longitude 76° 18.4670860' W.; thence northwesterly to the northern headland of Cranes Creek, Latitude 37° 48.8329168' N., Longitude 76° 18.7308073' W.; thence following the mean low water line northerly to a point on Sandy Point, said point being the point of beginning.

"Hand scrape" means any device or instrument with a catching bar having an inside measurement of no more than 22 inches, which is used or usable for the purpose of extracting or removing shellfish from a water bottom or the bed of a body of water.

"Hand tong" or "ordinary tong" means any pincers, nippers, tongs, or similar device used in catching oysters, which consist of two shafts or handles attached to opposable and complementary pincers, baskets, or containers operated entirely by hand, from the surface of the water and has no external or internal power source.

"James River Area" means those public grounds of the James River and Nansemond River west of the Monitor Merrimac Memorial Bridge Tunnel (Route I-664), northeast of the Mills E. Godwin, Jr. Bridge (U.S. Route 17) on the Nansemond River, and south of the James River Bridge (U.S. Route 17).

"James River Seed Area" means all public grounds and unassigned grounds in that area of the James River and its tributaries with a southeastern boundary beginning at a point on the shore on the south side of the river at Rainbow Farm Point in Isle of Wight County located at Latitude 37° 00.1965862' N., Longitude 76° 34.0712010' W.; thence north-northeasterly to a VMRC Marker "STH", Latitude 37° 00.9815328 N., Longitude 76° 33.5955842' W.; thence to a VMRC Marker "SMT", at Latitude 37° 01.3228160' N., Longitude 76° 33.3887351' W.; thence to the Flashing Green Channel Light #5, at Latitude 37° 02.3449949' N., Longitude 76° 32.7689936' W.; thence northeasterly to a VMRC Marker "NMT", Latitude 37° 02.7740540' N., Longitude 76° 32.0960864' W.; thence to a VMRC Marker "NTH" located at Latitude 37° 03.2030055' N., Longitude 76° 31.4231211' W.; thence to a point on the north shore of the river at Blunt (Blount) Point, in the City of Newport News, located at Latitude 37° 03.3805862' N., Longitude 76° 31.1444562' W.; the northern boundary, being a straight line, beginning at a point on the shore on the east side of the river in the City of Newport News, at Latitude 37° 08.4458787' N., Longitude 76° 37.2855533' W.; thence westerly to the southeast corner of the Deep Water Shoal State Replenishment Seed Area, Latitude 37° 08.4466039' N., Longitude 76° 37.4523346' W.; thence westerly to the southwest corner of the Deep Water Shoal State Replenishment Seed Area, Latitude 37° 08.4490472' N., Longitude 76° 38.0215554' W.; thence westerly to a point on the shore on the west side of the river at the mouth of Lawnes Creek in Isle of Wight County, Latitude 37° 08.4582990' N., Longitude 76° 40.2816023' W.

"Latitude and longitude" means values that are based upon a geodetic reference system of the North American Datum of 1983 (NAD83). When latitude and longitude are used in any area description, in conjunction with any physical landmark, to include aids to navigation, the latitude and longitude value is the legal point defining the boundary.

"Little Wicomico River" means that area of the Little Wicomico River inside of Public Ground 43 of Northumberland County, located in the Little Wicomico River near Bridge Creek, beginning at a point approximately 150 feet north of Peachtree Point, said point being Corner 1, located at Latitude 37° 53.2910650' N., Longitude 76°

16.7312926' W.; thence southwesterly to Corner 2, Latitude 37° 53.2601877' N., Longitude 76° 16.8662408' W.; thence northwesterly to Corner 3, Latitude 37° 53.2678470' N., Longitude 76° 16.8902408' W.; thence northeasterly to Corner 4, Latitude 37° 53.3113148' N., Longitude 76° 16.8211543' W.; thence southeasterly to Corner 1, said corner being the point of beginning.

"Milford Haven" means that area of Milford Haven inside of Public Ground 7 of Mathews County, beginning at a point approximately 1,380 feet east of Point Breeze, said point being Corner 1, located at Latitude 37° 28.3500000' N., Longitude 76° 16.5000000' W.; thence northeasterly to Corner 2, Latitude 37° 28.3700000' N., Longitude 76° 16.4700000' W.; thence southeasterly to Corner 3, Latitude 37° 28.3500000' N., Longitude 76° 16.4200000' W.; thence southwesterly to Corner 4, Latitude 37° 28.3200000' N., Longitude 76° 16.4500000' W.; thence northwesterly to Corner 1, said corner being the point of beginning.

"Mobjack Bay Area" means that area of Mobjack Bay consisting of Public Ground 25 of Gloucester County (Tow Stake) described as:

Public Ground 25 of Gloucester County, known as Tow Stake, is located in Mobjack Bay, near the mouth of the Severn River, beginning at a point approximately 2,880 feet east-northeast of Tow Stake Point, said point being Corner 1, located at Latitude 37° 20.3883888' N., Longitude 76° 23.5883836' W.; thence northeasterly to Corner 2, Latitude 37° 30.5910482' N., Longitude 76° 23.2372184' W.; thence southeasterly to Corner 3, Latitude 37° 20.3786971' N., Longitude 76° 22.7241180' W.; thence southwesterly to Corner 4, Latitude 37° 19.8616759' N., Longitude 76° 23.5914937' W.; thence northwesterly to Corner 5, Latitude 37° 20.0284019' N., Longitude 76° 23.7717423' W.; thence northeasterly to Corner 1, said corner being the point of beginning.

"Nomini Creek Area" means that area of Nomini Creek inside of Public Grounds 26 and 28 of Westmoreland County.

Public Ground 26 of Westmoreland County is located in Nomini Creek, north of Beales Wharf and east of Barnes Point, beginning at a point approximately 1,400 feet north of Barnes Point, said point being Corner 1, located at Latitude 38° 07.2690219' N., Longitude 76° 42.6784210' W.; thence southeasterly to Corner 2, Latitude 38° 07.0924060' N., Longitude 76° 42.4745767' W.; thence southwesterly to Corner 3, Latitude 38° 06.8394053' N., Longitude 76° 42.6704025' W.; thence northwesterly to Corner 4, Latitude 38° 06.8743004' N., Longitude 76° 42.7552151' W.; thence northeasterly to Corner 5, Latitude 38° 07.0569717' N., Longitude 76° 42.5603535' W.; thence northwesterly to Corner 1, said corner being the point of beginning.

Public Ground 28 of Westmoreland County is located at the mouth of Nomini Creek, beginning at a point approximately 50 feet west of White Oak Point, said point

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being Corner 1, located at Latitude 38° 07.6429987' N., Longitude 76° 43.0337082' W.; thence south-southeasterly to Corner 2, Latitude 38° 07.2987193' N., Longitude 76° 43.1101420' W.; thence northwesterly to Corner 3, Latitude 38° 07.7029267' N., Longitude 76° 43.3337762' W.; thence west to the mean low water line, Latitude 38° 07.7031535' N., Longitude 76° 43.3378345' W.; thence northerly and westerly along the mean low water line of Nomini Creek to a point southwest of Cedar Island, Latitude 38° 07.8986449' N., Longitude 76° 43.6329097' W.; thence northeasterly to a point on the mean low water line at the southern-most point of Cedar Island, Latitude 38° 07.8986449' N., Longitude 76° 43.6329097' W.; thence following the mean low water line of the southern and eastern sides of Cedar Island to a point, Latitude 38° 08.0164430' N., Longitude 76° 43.4773169' W.; thence northeasterly to Corner 4, Latitude 38° 08.0712849' N., Longitude 76° 43.4416606' W.; thence northeasterly to a point on the northern headland of Nomini Creek at the mean low water line, said point being Corner 5, Latitude 38° 08.2729626' N., Longitude 76° 43.3105315' W.; thence following the mean low water line of White Point to a point northwest of Snake Island, Corner 6, Latitude 38° 08.4066960' N., Longitude 76° 42.9105565' W.; thence southeast, crossing the mouth of Buckner Creek, to a point on the mean low water line of Snake Island, Corner 7, Latitude 38° 08.3698254' N., Longitude 76° 42.8939656' W.; thence southeasterly following the mean low water line of Snake Island to Corner 8, Latitude 38° 08.2333798' N., Longitude 76° 42.7778877' W.; thence south-southwesterly, crossing the mouth of Buckner Creek, to Corner 9, Latitude 38° 08.2134371' N., Longitude 76° 42.7886409' W.; thence southeasterly to a point on the mean low water line of the southern headland of Buckner Creek, Corner 10, Latitude 38° 08.1956281' N., Longitude 76° 42.7679625' W.; thence southwesterly following the mean low water line of Nomini Creek, crossing the mouth of an un-named cove at the narrowest point between the headlands and continuing to follow the mean low water line to a point on White Oak Point, Latitude 38° 07.6428228' N., Longitude 76° 43.0233530' W.; thence west to Corner 1, said point being the point of beginning.

"Oyster" means any shellfish of the species *Crassostrea virginica*.

"Oyster dredge" means any device having a maximum weight of 150 pounds with attachments, maximum width of 50 inches, and maximum tooth length of four inches.

"Oyster patent tong" means any patent tong not exceeding 100 pounds in gross weight, including any attachment other than rope and with the teeth not to exceed four inches in length.

"Oyster resource user fee" means a fee that must be paid each calendar year by anyone who grows, harvests, shucks, packs, or ships oysters for commercial purposes.

"Pocomoke Sound Area" means that area of Pocomoke Sound inside of Public Grounds 9 and 10 of Accomack County.

Public Ground 9 of Accomack County is located in the Pocomoke Sound, beginning at a corner on the Maryland-Virginia state line, located in the Pocomoke Sound approximately 1.06 nautical miles north-northeast of the northern-most point of North End Point, said point being Corner 1, located at Latitude 37° 57.2711566' N., Longitude 75° 42.2870790' W. (NAD83); thence east-northeasterly along the Maryland-Virginia state line to Corner 2, Latitude 37° 57.2896577' N., Longitude 75° 41.9790727' W.; thence southerly to Corner 3, Latitude 37° 57.2574850' N., Longitude 75° 41.9790730' W.; thence southwesterly to Corner 4, Latitude 37° 57.2288700' N., Longitude 75° 42.0077287' W.; thence west-southwesterly to Corner 5, Latitude 37° 57.2034533' N., Longitude 75° 42.1511250' W.; thence south-southwesterly to Corner 6, Latitude 37° 57.0940590' N., Longitude 75° 42.1935214' W.; thence south-southeasterly to Corner 7, Latitude 37° 57.0551726' N., Longitude 75° 42.1814457' W.; thence southwesterly to Corner 8, Latitude 37° 56.9408327' N., Longitude 75° 42.2957912' W.; thence south-southwesterly to Corner 9, Latitude 37° 56.6574947' N., Longitude 75° 42.3790819' W.; thence southwesterly to Corner 10, Latitude 37° 56.5790952' N., Longitude 75° 42.5228752' W.; thence west-southwesterly to Corner 11, Latitude 37° 56.5712564' N., Longitude 75° 42.5915437' W.; thence south-southeasterly to Corner 12, Latitude 37° 56.5441067' N., Longitude 75° 42.5869894' W.; thence southwesterly to Corner 13, Latitude 37° 56.4575045' N., Longitude 75° 42.7458050' W.; thence west-southwesterly to Corner 14, Latitude 37° 56.2575123' N., Longitude 75° 43.3791097' W.; thence southwesterly to Corner 15, Latitude 37° 55.7408688' N., Longitude 75° 43.7957804' W.; thence westerly to Corner 16, Latitude 37° 55.7575327' N., Longitude 75° 43.9458298' W.; thence northwesterly to Corner 17, Latitude 37° 55.8908661' N., Longitude 75° 44.1291309' W.; thence north-northeasterly to Corner 18, Latitude 37° 55.9908639' N., Longitude 75° 44.0791266' W.; thence northeasterly to Corner 19, Latitude 37° 56.1241858' N., Longitude 75° 43.8791328' W.; thence north-northeasterly to Corner 20, Latitude 37° 56.4075136' N., Longitude 75° 43.7291361' W.; thence northeasterly to Corner 21, Latitude 37° 56.8241664' N., Longitude 75° 43.2624601' W.; thence north-northeasterly to Corner 22, Latitude 37° 57.0706006' N., Longitude 75° 43.1480402' W.; thence east-northeasterly along the Maryland-Virginia state line to Corner 1, said corner being the point of beginning.

Public Ground 10 of Accomack County is located in the Pocomoke Sound, beginning at a corner on the Maryland-Virginia state line, located in the Pocomoke Sound approximately 2.3 nautical miles westerly of the northern-most point of North End Point, said point being Corner 1,

located at Latitude 37° 56.4741881' N., Longitude 75° 45.7051676' W. (NAD83); thence east-northeasterly along the Maryland-Virginia state line to Corner 2, Latitude 37° 56.9261140' N., Longitude 75° 43.7679786' W.; thence south-southwesterly to Corner 3, Latitude 37° 56.1241948' N., Longitude 75° 44.3624962' W.; thence west-southwesterly to Corner 4, Latitude 37° 56.0820561' N., Longitude 75° 44.5826292' W.; thence northerly to Corner 5, Latitude 37° 56.1377309' N., Longitude 75° 44.5817745' W.; thence west-southwesterly to Corner 6, Latitude 37° 56.1259751' N., Longitude 75° 44.6226859' W.; thence southwesterly to Corner 7, Latitude 37° 56.1039335' N., Longitude 75° 44.6692334' W.; thence southerly to Corner 8, Latitude 37° 56.0643616' N., Longitude 75° 44.6750106' W.; thence west-southwesterly to Corner 9, Latitude 37° 55.9742005' N., Longitude 75° 45.1458109' W.; thence west-northwesterly to Corner 10, Latitude 37° 56.0741973' N., Longitude 75° 45.8958329' W.; thence north-northwesterly to Corner 11, Latitude 37° 56.2565760' N., Longitude 75° 46.0000557' W.; thence northeasterly along the Maryland-Virginia state line to Corner 1, said corner being the point of beginning.

"Pocomoke and Tangier Sounds Management Area" or "PTSMA" means the area as defined in § 28.2-524 of the Code of Virginia.

"Pocomoke and Tangier Sounds Rotation Area 1" means all public grounds and unassigned grounds, within an area of the PTSMA, in Pocomoke and Tangier Sounds, bounded by a line beginning at a point on the Maryland-Virginia state line, located at Latitude 37° 54.6136000' N., Longitude 75° 53.9739600' W.; thence south to the house on Great Fox Island, Latitude 37° 53.6946500' N., Longitude 75° 53.8898800' W.; thence westerly to a point, Latitude 37° 53.3633500' N., Longitude 75° 56.5589600' W.; thence south to a point, Latitude 37° 48.4429100' N., Longitude 75° 56.4883600' W.; thence easterly to the north end of Watts Island, Latitude 37° 48.7757800' N., Longitude 75° 53.5994100' W.; thence northerly to the house on Great Fox Island, Latitude 37° 53.6946500' N., Longitude 75° 53.8898800' W.; thence southeasterly to Pocomoke Sound Shoal Flashing Light Red "8", Latitude 37° 52.4583300' N., Longitude 75° 49.4000000' W.; thence southeasterly to Messongo Creek Entrance Buoy Green Can "1", Latitude 37° 52.1000000' N., Longitude 75° 47.8083300' W.; thence southeast to Guilford Flats Junction Light Flashing 2+1 Red "GF", Latitude 37° 50.9533300' N., Longitude 75° 46.6416700' W.; thence southerly to a point on a line from Guilford Flats Junction Light to the northern-most point of Russell Island, where said line intersects the PTSMA boundary, Latitude 37° 48.4715943' N., Longitude 75° 46.9955932' W.; thence clockwise following the PTSMA boundary to a point on the Maryland-Virginia state line, said point being the point of beginning.

"Pocomoke and Tangier Sounds Rotation Area 2" means all public grounds and unassigned grounds, within an area of the

PTSMA, in Pocomoke and Tangier Sounds, bounded by a line beginning at the house on Great Fox Island, located at Latitude 37° 53.6946500' N., Longitude 75° 53.8898800' W.; thence southerly to the north end of Watts Island, Latitude 37° 48.7757800' N., Longitude 75° 53.5994100' W.; thence westerly to a point, Latitude 37° 48.4429100' N., Longitude 75° 56.4883600' W.; thence northerly to a point, Latitude 37° 53.3633500' N., Longitude 75° 56.5589600' W.; thence easterly to the house on Great Fox Island, said house being the point of beginning. Also, Pocomoke and Tangier Sounds Rotation Area 2 shall include all public grounds and unassigned grounds in the PTSMA in Pocomoke Sound bounded by a line beginning at a point on the Maryland-Virginia state line, Latitude 37° 54.6136000' N., Longitude 75° 53.9739600' W.; thence following the PTSMA boundary clockwise to a point on the line from the northern-most point of Russell Island to Guilford Flats Junction Light Flashing 2+1 Red "GF", where said line intersects the PTSMA boundary, Latitude 37° 48.4715943' N., Longitude 75° 46.9955932' W.; thence northerly to Guilford Flats Junction Light Flashing 2+1 Red "GF", Latitude 37° 50.9533300' N., Longitude 75° 46.6416700' W.; thence northwesterly to Messongo Creek Entrance Buoy Green Can "1", Latitude 37° 52.1000000' N., Longitude 75° 47.8083300' W.; thence northwesterly to Pocomoke Sound Shoal Flashing Light Red "8", Latitude 37° 52.4583300' N., Longitude 75° 49.4000000' W.; thence northwesterly to the house on Great Fox Island, Latitude 37° 53.6946500' N., Longitude 75° 53.8898800' W.; thence northerly to a point on the Maryland-Virginia state line, said point being the point of beginning.

"Public oyster ground" means all those grounds defined in § 28.2-551 of the Code of Virginia or by any other acts of the General Assembly pertaining to those grounds, all those grounds set aside by court order, and all those grounds set aside by order of the Marine Resources Commission, and may be redefined by any of these legal authorities.

"Rappahannock River Area 7" means all public grounds, in that area of the Rappahannock River, bounded downstream by a line from Rogue Point, located at Latitude 37° 40.0400000' N., Longitude 76° 32.2530000' W.; thence west-northwesterly to Flashing Red Buoy "8", Latitude 37° 40.1580000' N., Longitude 76° 32.9390000' W.; thence southwestly to Balls Point, Latitude 37° 39.3550000' N., Longitude 76° 34.4440000' W.; and bounded upstream by a line from Punchbowl Point, Latitude 37° 44.6750000' N., Longitude 76° 37.3250000' W.; thence southeasterly to Monaskon Point, Latitude 37° 44.0630000' N., Longitude 76° 34.1080000' W.

"Rappahannock River Area 8" means all public grounds, in that area of the Rappahannock River, bounded downstream by a line from Monaskon Point, located at Latitude 37° 44.0630000' N., Longitude 76° 34.1080000' W.; thence northwesterly to Punchbowl Point, Latitude 37° 44.6750000' N., Longitude 76° 37.3250000' W.; and bounded upstream by a line from Jones Point, Latitude 37° 46.7860000' N.,

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Longitude 76° 40.8350000' W.; thence north-northwesterly to Sharps Point, Latitude 37° 49.3640000' N., Longitude 76° 42.0870000' W.

"Rappahannock River Area 9" means all public grounds, in that area of the Rappahannock River, bounded downstream by a line from Sharps Point, located at Latitude 37° 49.3640000' N., Longitude 76° 42.0870000' W.; thence south-southeasterly to Jones Point, Latitude 37° 46.7860000' N., Longitude 76° 40.8350000' W.; and bounded upstream by the Thomas J. Downing Bridge (U.S. Route 360).

"Rappahannock River Rotation Area 1" means all public grounds, in that area of the Rappahannock River and Chesapeake Bay, bounded by a line offshore and across the mouth of the Rappahannock River from a point on the mean low water line of Windmill Point, located at Latitude 37° 36.8200000' N., Longitude 76° 16.9460000' W.; thence southeast to Windmill Point Light, Latitude 37° 35.7930000' N., Longitude 76° 14.1800000' W.; thence southwesterly to Stingray Point Light, Latitude 37° 33.6730000' N., Longitude 76° 16.3620000' W.; thence westerly to a point on the mean low water line of Stingray Point, Latitude 37° 33.6920000' N., Longitude 76° 17.9860000' W.; and bounded upstream by a line from the mean low water line west of Broad Creek, Latitude 37° 33.9520000' N., Longitude 76° 19.3090000' W.; thence northeasterly to a VMRC Buoy on the Baylor line, Latitude 37° 34.5310000' N., Longitude 76° 19.1430000' W.; thence northeasterly to a VMRC Buoy, Latitude 37° 34.6830000' N., Longitude 76° 19.1000000' W.; thence northwesterly to a VMRC Buoy, Latitude 37° 35.0170000' N., Longitude 76° 19.4500000' W.; thence northwesterly to Sturgeon Bar Light "7R", Latitude 37° 35.1500000' N., Longitude 76° 19.7330000' W.; thence continuing northwesterly to Mosquito Point Light "8R", Latitude 37° 36.1000000' N., Longitude 76° 21.3000000' W.; thence northwesterly to the southern-most corner of the house on Mosquito Point, Latitude 37° 36.5230000' N., Longitude 76° 21.5950000' W.

"Rappahannock River Rotation Area 2" means all public grounds, in that area of the Rappahannock River, bounded downstream by a line from the southern-most corner of the house on Mosquito Point, located at Latitude 37° 36.5230000' N., Longitude 76° 21.5950000' W.; thence southeast to Mosquito Point Light "8R", Latitude 37° 36.1000000' N., Longitude 76° 21.3000000' W.; thence continuing southeasterly to Sturgeon Bar Beacon "7R", Latitude 37° 35.1500000' N., Longitude 76° 19.7330000' W.; thence west-southwesterly to a VMRC Buoy, Latitude 37° 34.9330000' N., Longitude 76° 21.0500000' W.; thence southwesterly to a VMRC Buoy, Latitude 37° 34.8830000' N., Longitude 76° 21.1000000' W.; thence southwesterly to a pier west of Hunting Creek at Grinels, Latitude 37° 34.4360000' N., Longitude 76° 26.2880000' W.; and bounded on the upstream by a line from Mill Creek Channel Marker "4", Latitude 37° 35.0830000' N., Longitude 76° 26.9500000' W.; thence northeasterly to Mill Creek Channel Marker "2", Latitude 37°

35.4830000' N., Longitude 76° 24.5670000' W.; thence northeasterly to the southern-most corner of the house on Mosquito Point, Latitude 37° 36.5230000' N., Longitude 76° 21.5950000' W.

"Rappahannock River Rotation Area 3" means all public grounds, in that area of the Rappahannock River, beginning from the north channel fender at the Robert O. Norris, Jr. Bridge, located at Latitude 37° 37.4830000' N., Longitude 76° 25.3450000' W.; thence southeast to the southern-most corner of the house on Mosquito Point, Latitude 37° 36.5230000' N., Longitude 76° 21.5950000' W.; thence southwest to Mill Creek Channel Marker "2", Latitude 37° 35.4830000' N., Longitude 76° 24.5670000' W.; thence southwesterly to Mill Creek Channel Marker "4", Latitude 37° 35.0830000' N., Longitude 76° 24.9500000' W.; thence northeasterly to Parrotts Creek Channel Marker "1", Latitude 37° 36.0330000' N., Longitude 76° 25.4170000' W.; thence northerly to VMRC Buoy, Latitude 37° 36.3330000' N., Longitude 76° 25.2000000' W.; thence northerly to the north channel fender of the Robert O. Norris, Jr. Bridge, said point being the point of beginning.

"Rappahannock River Rotation Area 4" means all public grounds, in that area of the Rappahannock River, Corrotoman River and Carter Creek, beginning at the White Stone end of the Robert O. Norris, Jr. Bridge (State Route 3), located at Latitude 37° 38.1290000' N., Longitude 76° 24.7220000' W.; thence along said bridge to the north channel fender, Latitude 37° 37.4830000' N., Longitude 76° 25.3450000' W.; thence westerly to the VMRC Buoy "5-4", Latitude 37° 38.0050000' N., Longitude 76° 30.0280000' W.; thence northerly to Old House Point, Latitude 37° 39.1390000' N., Longitude 76° 29.6850000' W.; thence northeasterly to Ball Point, Latitude 37° 41.6600000' N., Longitude 76° 28.6320000' W.; thence southeasterly to VMRC reef marker "Ferry Bar – North", Latitude 37° 40.3000000' N., Longitude 76° 28.5000000' W.; thence southwesterly to VMRC reef marker "Ferry Bar – South", Latitude 37° 40.1670000' N., Longitude 76° 28.5830000' W.; thence southeasterly to a duck blind west of Corrotoman Point, Latitude 37° 39.8760000' N., Longitude 76° 28.4200000' W.; thence southerly to VMRC Buoy "543", Latitude 37° 39.2670000' N., Longitude 76° 27.8500000' W.; thence southerly to VMRC Buoy "Drumming-West", Latitude 37° 38.8830000' N., Longitude 76° 27.6830000' W.; thence southerly to VMRC Buoy "Drumming-East", Latitude 37° 38.8330000' N., Longitude 76° 27.5670000' W.; thence northeasterly to Orchard Point, Latitude 37° 38.9240000' N., Longitude 76° 27.1260000' W.

"Rappahannock River Rotation Area 5" means all public grounds, in that area of the Rappahannock River, beginning at the Greys Point end of the Robert O. Norris, Jr. Bridge (State Route 3), located at Latitude 37° 36.8330000' N., Longitude 76° 25.9990000' W.; thence northeasterly along the bridge to the north channel fender, Latitude 37° 37.4830000' N., Longitude 76° 25.3450000' W.; thence west-northwesterly to VMRC Buoy "5-4", Latitude 37° 38.0050000' N., Longitude

76° 30.0280000' W.; thence westerly to Buoy "R6", Latitude 37° 38.0330000' N., Longitude 76° 30.2830000' W.; thence south to the eastern headland of Whiting Creek, Latitude 37° 36.6580000' N., Longitude 76° 30.3120000' W.

"Rappahannock River Rotation Area 6" means all public grounds, in that area of the Rappahannock River, beginning on the eastern headland of Whiting Creek, located at Latitude 37° 36.6580000' N., Longitude 76° 30.3120000' W.; thence north to Buoy "R6", Latitude 37° 38.0330000' N., Longitude 76° 30.2830000' W.; thence northwesterly to VMRC White House Sanctuary Buoy, Latitude 37° 38.1500000' N., Longitude 76° 30.5330000' W.; thence northwesterly to VMRC Towles Point Area Buoy, Latitude 37° 38.8330000' N., Longitude 76° 31.5360000' W.; thence northwesterly to Flashing Red Buoy "8" off Rogue Point, Latitude 37° 40.1580000' N., Longitude 76° 32.9390000' W.; thence southwesterly to Balls Point, Latitude 37° 39.3550000' N., Longitude 76° 34.4440000' W.

"Seed oyster" means any oyster taken by any person from natural beds, rocks, or shoals that is more than 30 days from harvest for human consumption.

"Thomas Rock Area" means all public grounds and unassigned grounds, in that area of the James River, with an eastern boundary being the upstream side of the James River Bridge (U.S. Route 17), and a western boundary being a line drawn from the south side of the river at Rainbow Farm Point, a point on the shore, in line with VMRC Markers "STH" and "SMT", located at Latitude 37° 00.1965862' N., Longitude 76° 34.0712010' W.; thence north-northeasterly to a VMRC Marker "STH", Latitude 37° 00.9815328' N., Longitude 76° 33.5955842' W.; thence to a VMRC Marker "SMT", at Latitude 37° 01.3228160' N., Longitude 76° 33.3887351' W.; thence to the Flashing Green Channel Light #5, at Latitude 37° 02.3449949' N., Longitude 76° 32.7689936' W.; thence northeasterly to a VMRC Marker "NMT", Latitude 37° 02.7740540' N., Longitude 76° 32.0960864' W.; thence to a VMRC Marker "NTH" located at Latitude 37° 03.2030055' N., Longitude 76° 31.4231211' W.; thence to a point on the north shore of the river at Blunt (Blount) Point, said point being in line with VMRC Markers "NMT" and "NTH" and located at Latitude 37° 03.3805862' N., Longitude 76° 31.1444562' W.

"Unassigned ground" means all ~~those grounds defined by any other acts of the General Assembly pertaining to those grounds, all those grounds not assigned pursuant to §§ 28.2-600 through 28.2-633 of the Code of Virginia, established pursuant to § 28.2-551 of the Code of Virginia, or set aside by court order, and all or those grounds set aside by order of declarations or regulation by~~ the Marine Resources Commission, and may be redefined by any of these legal authorities.

"Upper Chesapeake Bay - Blackberry Hangs Area" means all public grounds and unassigned grounds, in that area of the Chesapeake Bay, bounded by a line, beginning at a point

approximately 300 feet east of the mean low water line of the Chesapeake Bay and approximately 1,230 feet southwest of the end of the southern-most stone jetty at the mouth of the Little Wicomico River, said point being Corner 1, Latitude 37° 53.1811193' N., Longitude 76° 14.1740146' W.; thence east-southeasterly to Corner 2, Latitude 37° 52.9050025' N., Longitude 76° 11.9357257' W.; thence easterly to Corner 3, Latitude 37° 52.9076552' N., Longitude 76° 11.6098145' W.; thence southwesterly to Corner 4, Latitude 37° 52.8684955' N., Longitude 76° 11.6402444' W.; thence east-southeasterly to Corner 5, Latitude 37° 52.7924853' N., Longitude 76° 11.0253352' W.; thence southwesterly to Corner 6, Latitude 37° 49.4327736' N., Longitude 76° 13.2409959' W.; thence northwesterly to Corner 7, Latitude 37° 50.0560555' N., Longitude 76° 15.0023234' W.; thence north-northeasterly to Corner 8, Latitude 37° 50.5581183' N., Longitude 76° 14.8772805' W.; thence north-northeasterly to Corner 9, Latitude 37° 52.0260950' N., Longitude 76° 14.5768550' W.; thence northeasterly to Corner 1, said corner being the point of beginning.

"Yeocomico River Area" means that area of the North West Yeocomico River, inside Public Ground 8 of Westmoreland County and those areas of the South Yeocomico River inside Public Grounds 102, 104, 106, and 107 of Northumberland County.

Public Ground 8 of Westmoreland County is located in the North West Yeocomico River, beginning at a point approximately 1,455 feet northeast of Crow Bar and 1,850 feet northwest of White Point, said point being Corner 1, located at Latitude 38° 02.7468214' N., Longitude 76° 33.0775726' W.; thence southeasterly to Corner 2, Latitude 38° 02.7397202' N., Longitude 76° 33.0186286' W.; thence southerly to Corner 3, Latitude 38° 02.6021644' N., Longitude 76° 33.0234175' W.; thence westerly to Corner 4, Latitude 38° 02.6006669' N., Longitude 76° 33.0824799' W.; thence northerly to Corner 1, said corner being the point of beginning.

Public Ground 102 of Northumberland County is located in the South Yeocomico River, beginning at a point approximately 630 feet south of Mundy Point and 1,745 feet southwest of Tom Jones Point, said point being Corner 1, located at Latitude 38° 01.2138059' N., Longitude 76° 32.5577201' W.; thence east-northeasterly to Corner 2, Latitude 38° 01.2268644' N., Longitude 76° 32.4497849' W.; thence southwesterly to Corner 3, Latitude 38° 01.1091209' N., Longitude 76° 32.5591101' W.; thence northerly to Corner 1, said corner being the point of beginning.

Public Ground 104 of Northumberland County is located in the South Yeocomico River, beginning at a point approximately 670 feet north of Walker Point and 1,900 feet northwest of Palmer Point, said point being Corner 1, located at Latitude 38° 00.8841841' N., Longitude 76° 32.6106215' W.; thence southeasterly to Corner 2, Latitude

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38° 00.8609163' N., Longitude 76° 32.5296302' W.; thence southeasterly to Corner 3, Latitude 38° 00.6693092' N., Longitude 76° 32.4161866' W.; thence southwesterly to Corner 4, Latitude 38° 00.6418466' N., Longitude 76° 32.5394849' W.; thence northwesterly to Corner 1, said corner being the point of beginning.

Public Ground 106 of Northumberland County is located in Palmer Cove of the South Yeocomico River, beginning at a point, on the mean low water line approximately 2,000 feet east of northern headland of Palmer Cove, said point being Corner 1, located at Latitude 38° 00.6914018' N., Longitude 76° 31.8629027' W.; thence southwesterly to Corner 2, Latitude 38° 00.6685187' N., Longitude 76° 31.8798151' W.; thence westerly to Corner 3, Latitude 38° 00.6614246' N., Longitude 76° 32.1278647' W.; thence northerly to Corner 4, Latitude 38° 00.7079228' N., Longitude 76° 32.1338276' W., said point being a point on the mean low water line; thence following the mean low water line in a clockwise direction to Corner 1, said corner being the point of beginning.

Public Ground 107 of Northumberland County is located in the South Yeocomico River, beginning at a point approximately 1,000 feet southwest of Barn Point and 1,300 feet northwest of Tom Jones Point, said point being Corner 1, located at Longitude 38° 01.1389367' N., Latitude 76° 32.3425617' W.; thence east-southeasterly to Corner 2, Latitude 38° 01.4106421' N., Longitude 76° 32.1077962' W.; thence southwesterly to Corner 3, Latitude 38° 01.2717197' N., Longitude 76° 32.2917989' W.; thence north-northwesterly to Corner 1, said corner being the point of beginning.

"York River Rotation Area 1" means all public grounds in the York River, within Gloucester County, between a line from Upper York River Flashing Red Channel Marker "8", Latitude 37° 17.8863666' N., Longitude 76° 34.6534166' W.; thence northeasterly to Red Day Marker "2" at the mouth of Cedar Bush Creek, Latitude 37° 18.6422166' N., Longitude 76° 33.8216000' W.; upstream to a line from the Flashing Yellow VIMS Data Buoy "CB", Latitude 37° 20.4670000' N., Longitude 76° 37.4830000' W.; thence northeasterly to the inshore end of the wharf at Clay Bank.

"York River Rotation Area 2" means all public grounds in the York River, within Gloucester County, from the George P. Coleman Memorial Bridge (U.S. Route 17), upstream to a line from Upper York River Flashing Red Channel Marker "8", Latitude 37° 17.8863666' N., Longitude 76° 34.6534166' W.; thence northeasterly to Red Day Marker "2" at the mouth of Cedar Bush Creek, Latitude 37° 18.6422166' N., Longitude 76° 33.8216000' W.

4VAC20-720-35. Public oyster ground harvest season.

The ~~Commissioner of the~~ Marine Resources Commission shall be authorized to extend the public oyster harvest season in the James River Seed Area, including the Deep Water

Shoal State Replenishment Area, but the extension shall not be established to go beyond June 30.

4VAC20-720-40. Open oyster harvest season and areas.

A. It shall be unlawful for any person to harvest oysters from public and unassigned grounds outside of the seasons and areas set forth in this section.

B. It shall be unlawful to harvest clean cull oysters from the public oyster grounds and unassigned grounds except during the lawful seasons and from the lawful areas as described in the following subdivisions of this subsection.

1. James River Seed Area, including the Deep Water Shoal State Replenishment Seed Area: October 1, ~~2015~~ 2016, through April 30, ~~2016~~ 2017.
2. Milford Haven: December 1, ~~2015~~ 2016, through February ~~29, 2016~~ 28, 2017.
3. Rappahannock River Area 9: November 1, ~~2015~~ 2016, through December 31, ~~2015~~ 2016.
4. Little Wicomico River: October 1, ~~2015~~ 2016, through December 31, ~~2015~~ 2016.
5. Coan River: October 1, ~~2015~~ 2016, through December 31, ~~2015~~ 2016.
6. Yeocomico River: October 1, ~~2015~~ 2016, through December 31, ~~2015~~ 2016. Except for Public Ground 106 that will be open December 1, 2016, through December 31, 2016.
7. Nomini Creek: October 1, ~~2015~~ 2016, through December 31, ~~2015~~ 2016.
8. ~~Mobjack Bay Area~~ York River Rotation Area 2: January 1, ~~2016~~ 2017, through January 31, ~~2016~~ 2017.
9. Rappahannock River Rotation Area ~~5~~ 4: October 1, ~~2015~~ 2016, through ~~November 30, 2015~~ October 31, 2016, and December 1, 2016, through December 31, 2016.
10. Rappahannock River Rotation Area ~~3~~ 2: November 1, ~~2015~~ 2016, through December 31, ~~2015~~ 2016.
11. Great Wicomico River Area: December 1, ~~2015~~ 2016, through January 31, ~~2016~~ 2017.
12. Upper Chesapeake Bay - Blackberry Hangs Area: December 1, ~~2015~~ 2016, through January 31, ~~2016~~ 2017.
13. James River Area and the Thomas Rock Area (James River): November 1, ~~2015~~ 2016, through ~~December 31, 2015 and January 1, 2016~~, through January 31, ~~2016~~ 2017.
14. Pocomoke and Tangier Sounds Rotation Area ~~4~~ 2: December 1, ~~2015~~ 2016, through February ~~29, 2016~~ 28, 2017.
15. ~~Pocomoke Sound Area—Public Ground 10~~: November ~~2, 2015, through November 13, 2015.~~
16. ~~Pocomoke Sound Area—Public Ground 9~~: November ~~16, 2015, through November 27, 2015.~~
17. 15. Deep Rock Area: December 1, ~~2015~~ 2016, through February ~~29, 2016~~ 28, 2017.

~~18.~~ 16. Seaside of the Eastern Shore (for clean cull oysters only): November 1, ~~2015~~ 2016, through March 31, ~~2016~~ 2017.

C. It shall be unlawful to harvest seed oysters from the public oyster grounds or unassigned grounds, except during the lawful seasons. The harvest of seed oysters from the lawful areas is described in the following subdivisions of this subsection.

1. James River Seed Area: October 1, ~~2015~~ 2016, through May 31, ~~2016~~ 2017.

2. Deep Water Shoal State Replenishment Seed Area: October 1, ~~2015~~ 2016, through May 31, ~~2016~~ 2017.

4VAC20-720-60. Day and time limit.

A. It shall be unlawful to take, catch, or possess oysters on Saturday and Sunday from the public oyster grounds or unassigned grounds in the waters of the Commonwealth of Virginia, for commercial purposes, except that this provision shall not apply to any person harvesting no more than one bushel per day by hand or ordinary tong for household use only during the season when the public oyster grounds or unassigned grounds are legally open for harvest.

B. From October 1, ~~2015~~ 2016, through December 31, ~~2015~~ 2016, it shall be unlawful to take, catch, or possess oysters on any Friday from the public oyster grounds or unassigned grounds described in 4VAC20-720-40 B 9 through B ~~14~~ 14.

C. It shall be unlawful for any person to harvest or attempt to harvest oysters prior to sunrise or after 2 p.m. from the areas described in 4VAC20-720-40 B 1 through B ~~17~~ 15 and 4VAC20-720-40 C. In addition, it shall be unlawful for any boat with an oyster dredge aboard to leave the dock until one hour before sunrise or return to the dock after sunset, and it shall be unlawful for any boat with a hand scrape aboard to leave the dock until one-half hour before sunrise or return to the dock after sunset.

4VAC20-720-70. Gear restrictions.

A. It shall be unlawful for any person to harvest oysters in the James River Seed Area, including the Deep Water Shoal State Replenishment Seed Area, the Rappahannock River Area 9, Milford Haven, Little Wicomico River, Coan River, Nomini Creek and Yeocomico River, except by hand tong. It shall be unlawful for any person to have a hand scrape on board a boat that is harvesting or attempting to harvest oysters from public grounds by hand tong.

B. It shall be unlawful to harvest oysters from the seaside of the Eastern Shore area by any gear, except by hand or hand tong.

C. It shall be unlawful to harvest oysters in the Rappahannock River Rotation Areas ~~3~~ 2 and ~~5~~ 4, James River Area, Thomas Rock Area, Upper Chesapeake Bay Blackberry Hangs Area, ~~Mobjack Bay~~ York River Area, and Great Wicomico River Area, ~~and Pocomoke Sound Area~~ Public Ground 9 and 10, by any gear except by hand scrape.

D. It shall be unlawful for any person to have more than one hand scrape on board any boat that is harvesting oysters or attempting to harvest oysters from public grounds. It shall be unlawful for any person to have a hand tong on board a boat that is harvesting or attempting to harvest oysters from public grounds by hand scrape.

E. It shall be unlawful to harvest oysters from the Pocomoke and Tangier Sounds Rotation Area ~~4~~ 2, except by an oyster dredge.

F. It shall be unlawful to harvest oysters from the Deep Rock Area, except by an oyster patent tong.

4VAC20-720-75. Gear license.

A. It shall be unlawful for any person to harvest shellfish from the hand scrape areas in the Rappahannock River, James River, Upper Chesapeake Bay, ~~Mobjack Bay~~ York River Area, and Great Wicomico River, ~~and Pocomoke Sound Area~~ Public Ground 9 and 10, unless that person has first obtained a valid hand scrape license.

B. It shall be unlawful for any person to harvest shellfish with an oyster dredge from the public oyster grounds in the Pocomoke and Tangier Sounds Rotation Area ~~4~~ 2, unless that person has first obtained a valid oyster dredge license.

C. It shall be unlawful for any person to harvest shellfish with a patent tong from the public oyster grounds in the Deep Rock Area, unless that person has first obtained a valid oyster patent tong license.

D. It shall be unlawful for any person to harvest shellfish with a hand tong from the public oyster grounds, as described in 4VAC20-720-70 A, unless that person has first obtained a valid hand tong license.

E. It shall be unlawful for any person to harvest shellfish by hand from the public oyster grounds on the seaside of the Eastern Shore, as described in 4VAC20-720-70 B, unless that person has first obtained a valid oyster by hand license. It shall be unlawful for any person to harvest shellfish from the public oyster grounds on the seaside of the Eastern Shore by hand tong, as described in 4VAC20-720-70 B, unless that person has first obtained a valid oyster hand tong license.

4VAC20-720-80. Quotas and harvest limits.

A. It shall be unlawful for any person who does not possess a valid commercial fisherman's registration license and a valid gear license required by harvest area, as described in 4VAC20-720-75, and has not paid the current year's oyster resource user fee to harvest or possess any oysters for commercial purposes. Any individual who possesses the valid licenses and has paid the oyster resource user fee as described in this subsection shall be limited to a maximum harvest of eight bushels per day. It shall be unlawful for any vessel to exceed a daily vessel limit of 24 bushels clean cull oysters harvested from the areas described in 4VAC20-720-40 B 8 through ~~16~~ 15.

B. It shall be unlawful for any person who does not possess a valid commercial fisherman's registration license and a

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valid gear license required by harvest area, as described in 4VAC20-720-75, and has not paid the current year's oyster resource user fee to harvest or possess any oysters for commercial purposes. Any individual who possesses the valid licenses and has paid the oyster resource user fee as described in this subsection shall be limited to a maximum harvest of eight bushels per day. It shall be unlawful for any vessel to exceed a daily vessel limit for clean cull oysters harvested from the areas described in 4VAC20-720-40 B 2 through 7 and ~~7~~ 16, whereby that vessel limit shall equal the number of registered commercial fisherman licensees on board the vessel who hold a valid gear license and who have paid the oyster resource user fee multiplied by eight.

C. It shall be unlawful for any vessel to exceed a daily vessel limit for clean cull oysters harvested from the areas described in 4VAC20-720-40 B 1, whereby that vessel limit shall equal the number of registered commercial fisherman licensees on board the vessel who hold a valid gear license and who have paid the oyster resource user fee multiplied by 12. It shall be unlawful for any person who does not possess a valid commercial fisherman's registration license and hold a valid gear license required by harvest area, as described in 4VAC20-720-75, and has not paid the current year's oyster resource user fee to harvest or possess any oysters for commercial purposes. Any individual who possesses the valid licenses and has paid the oyster resource user fee as described in this subsection shall be limited to a maximum harvest of 12 bushels per day.

~~D. It shall be unlawful for any vessel to exceed a daily vessel limit for clean cull oysters harvested from the areas described in 4VAC20-720-40 B 18, whereby that vessel limit shall equal the number of registered commercial fisherman licensees on board the vessel who are licensed by a valid gear license and have paid the oyster resource user fee, multiplied by eight. It shall be unlawful for any person who does not possess a valid commercial fisherman's registration license and a valid gear license required by harvest area, as described in 4VAC20-720-75, and has not paid the current year's oyster resource user fee to harvest or possess any oysters for commercial purposes. Any individual who possesses the valid licenses and has paid the oyster resource user fee, as described in this subsection, shall be limited to a maximum harvest of eight bushels per day.~~

~~E. Beginning February 23, 2016, payment of the oyster resource user fee that allows any harvester to use one or more gear types to harvest oysters or possess any bushel limit, as described in this section, shall be limited to those individuals who previously paid an oyster resource user fee. Beginning on May 1, 2016, payment of the oyster resource user fee shall be limited to (i) those individuals who previously paid an oyster resource user fee and (ii) those persons who wish to obtain an oyster hand tong license for the purpose of harvesting seed oysters.~~

~~F. In the Pocomoke and Tangier Sounds Rotation Area 4 2, no blue crab bycatch is allowed. It shall be unlawful to possess on board any vessel more than 250 hard clams.~~

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (4VAC20-720)

[Daily Harvest Information For James River Seed Area, Including The Deep Water Shoal State Replenishment Seed Area \(eff. 11/11\).](#)

[Commercial Oyster Resource User Fee Transfer Application \(undated\)](#)

VA.R. Doc. No. R17-4866; Filed August 26, 2016, 2:36 p.m.

TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

CRIMINAL JUSTICE SERVICES BOARD

Final Regulation

Title of Regulation: **6VAC20-30. Rules Relating to Compulsory In-Service Training Standards for Law-Enforcement Officers, Jailors or Custodial Officers, Courtroom Security Officers, Process Service Officers and Officers of the Department of Corrections, Division of Operations (amending 6VAC20-30-20, 6VAC20-30-30, 6VAC20-30-80; repealing 6VAC20-30-110, 6VAC20-30-120, 6VAC20-30-130).**

Statutory Authority: § 9.1-102 of the Code of Virginia.

Effective Date: October 20, 2016.

Agency Contact: Barbara Peterson-Wilson, Law Enforcement Program Coordinator, Department of Criminal Justice Services, 1100 Bank Street, Richmond, VA 23219, telephone (804) 225-4503, FAX (804) 786-0410, or email barbara.peterson-wilson@dcjs.virginia.gov.

Summary:

The amendments (i) increase the number of annual training hours that correctional officers and sergeants employed in the state prison system must complete from 24 hours to 40 hours and (ii) remove the lists of firearms qualification courses from the regulation and, instead, direct interested parties to a document of approved courses on the Department of Criminal Justice Services website.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

6VAC20-30-20. Applicability.

A. Every person employed as a law-enforcement officer, as defined by § 9.1-101 of the Code of Virginia, shall meet compulsory in-service training standards as set forth in 6VAC20-30-30 A.

B. Every person employed as a jailor or custodial officer under the provisions of Title 53.1 of the Code of Virginia shall meet compulsory in-service training standards as set forth in 6VAC20-30-30 B.

C. Every person employed as a courtroom security or process service officer under the provisions of Title 53.1 of the Code of Virginia shall meet compulsory in-service training standards as set forth in 6VAC20-30-30 C.

D. Every person employed as an officer of the Department of Corrections, Division of Operations as defined herein shall meet compulsory in-service training standards as set forth in 6VAC20-30-30 ~~D~~ A.

6VAC20-30-30. Compulsory in-service training standards.

Pursuant to the provisions of subdivisions ~~(1), (3), (5), (6) and (7)~~ 1, 3, 4, 5, 7, 8, and 9 of § 9.1-102 of the Code of Virginia, the board establishes the following as the compulsory in-service training standards for law-enforcement officers, jailors or custodial officers, courtroom security officers, process service officers and officers of the Department of Corrections, Division of Operations.

A. Law-enforcement officers and corrections officers...
TOTAL 40 Hours

- 1. Cultural diversity training... 2 Hours
- 2. Legal training... 4 Hours

Subjects to be provided are at the discretion of the academy director of a certified training academy and shall be designated as legal training.

- 3. Career development/elective training... 34 Hours

~~(May include subjects provided in subsections B and C of this section.)~~

a. Subjects to be provided are at the discretion of the academy director of a certified training academy. ~~No more than eight hours of firearms training shall be approved as elective subjects. Firearms training shall be applied as follows:~~

- ~~(1) b. No more than four hours may be applied to firearms qualification as provided in 6VAC20-30-80; and.~~
- ~~(2) Remaining hours eligible for situational or decision-making training.~~

B. Jailors or custodial officers... TOTAL 24 Hours

- 1. Cultural diversity training... 2 Hours
- 2. Legal training... 4 Hours

Subjects to be provided are at the discretion of the academy director of a certified training academy and shall be designated as legal training.

3. Career development/elective training... 18 Hours

~~(May include subjects provided in subsections A and C of this section.)~~

a. Subjects to be provided are at the discretion of the academy director of a certified training academy. ~~No more than eight hours of firearms training shall be approved as elective subjects. Firearms training shall be applied as follows:~~

- ~~(1) b. No more than four hours may be applied to firearms qualification as provided in 6VAC20-30-80; and.~~
- ~~(2) Remaining hours eligible for situational or decision-making training.~~

C. Courtroom security officers and process service officers...
TOTAL 16 Hours

- 1. Cultural diversity training... 2 Hours
- 2. Legal training... 4 Hours

Subjects to be provided are at the discretion of the academy director of a certified training academy and shall be designated as legal training.

3. Career development/elective training... 10 Hours

~~(May include subjects provided in subsections A and B of this section.)~~

a. Subjects to be provided are at the discretion of the academy director of a certified training academy. ~~No more than eight hours of firearms training shall be approved as elective subjects. Firearms training shall be applied as follows:~~

- ~~(1) b. No more than four hours may be applied to firearms qualification as provided in 6VAC20-30-80; and.~~
- ~~(2) Remaining hours eligible for situational and/or decision making training.~~

~~D. Officers of the Department of Corrections, Division of Operations.~~

~~Total Hours for Correctional Officers and Sergeants... 24 Hours~~

Total Hours for Lieutenants through Wardens... 40 Hours

- 1. Cultural diversity training... 2 Hours
- 2. Legal training... 4 Hours

~~The subjects to be provided are at the discretion of the Director of the Department of Corrections or his designee and shall be designated as legal training.~~

~~3. Career development/elective training.~~

~~Correctional officers and sergeants... 18 Hours~~

~~Lieutenants through wardens... 34 Hours~~

~~a. Subjects to be provided are at the discretion of the Director of the Department of Corrections, or his designee. No more than eight hours of firearms training~~

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~~shall be approved as elective subjects. Firearms training shall be applied as follows:~~

~~(1) No more than four hours applied to firearms qualification as provided in 6VAC20-30-80; and~~

~~(2) Remaining hours eligible for situational or decision making training.~~

6VAC20-30-80. Firearms training.

A. Every criminal justice officer required to carry a firearm in the performance of duty shall qualify annually using the applicable firearms course approved by the Committee on Training of the board. The list of approved courses is identified under the performance outcomes for weapons and firearms training in the Virginia Criminal Justice Services Training Manual and Compulsory Minimum Training Standards available on the Department of Criminal Justice Services' website at [<http://www.dcjs.virginia.gov/eple/> <http://www.dcjs.virginia.gov/law-enforcement>]. Annual range qualification shall include a review of issues/policy relating to weapons safety, nomenclature, maintenance and use of force. With prior approval of the director, a reasonable modification of the firearms course may be approved to accommodate qualification on indoor ranges. No minimum number of hours is required.

~~A. 1.~~ Law-enforcement officers, jailors or custodial officers, courtroom security officers, and process service officers shall qualify annually with a minimum passing score of 70% on one of the ~~following applicable firearms courses required by subsection A of this section.~~

~~1. Virginia Modified Double Action Course for Semi-Automatic Pistols and Revolvers.~~

~~2. Virginia Modified Combat Course I.~~

~~3. Virginia Modified Combat Course II.~~

~~4. Virginia Qualification Course I.~~

~~5. Virginia Qualification Course II.~~

~~6. Virginia Tactical Qualification Course I.~~

~~7. Virginia Tactical Qualification Course II.~~

B. 2. Officers of the Department of Corrections, Division of Operations shall qualify annually with a minimum passing score of 70% on one of the applicable firearms courses required by subsection A of this section.

~~Handgun.~~

~~Department of Corrections Virginia Modified Double Action Combat Course.~~

C. ~~Law enforcement~~ B. Possession of or immediate availability of special weapons by law-enforcement officers, jailors or custodial officers, courtroom security officers, civil process officers and officers of the Department of Corrections, Division of Operations.

~~Special weapons.~~

a. 1. All agencies whose personnel possess, or have available for immediate use, shotguns or other similar

special weapons, shall design an appropriate qualification weapons program and require all applicable personnel to complete annually.

b. 2. The course, number of rounds to be fired and qualification score shall be determined by the agency or approved training school. Documentation of such qualification programs shall be available for inspection by the director or staff.

6VAC20-30-110. ~~Effective date. (Repealed.)~~

~~These rules shall be effective on and after July 1, 1992, and until amended or repealed.~~

6VAC20-30-120. ~~Adopted. (Repealed.)~~

~~This chapter was adopted July 11, 1974.~~

6VAC20-30-130. ~~Amended. (Repealed.)~~

~~This chapter was amended:~~

~~January 1, 1988~~

~~May 3, 1989~~

~~April 1, 1992~~

VA.R. Doc. No. R15-4108; Filed August 23, 2016, 3:58 p.m.

TITLE 9. ENVIRONMENT

VIRGINIA WASTE MANAGEMENT BOARD

Forms

REGISTRAR'S NOTICE: Forms used in administering the following regulation have been filed by the Virginia Waste Management Board. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

Title of Regulation: **9VAC20-90. Solid Waste Management Permit Action Fees and Annual Fees.**

Contact Information: Melissa Porterfield, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, or email melissa.porterfield@deq.virginia.gov.

FORMS (9VAC20-90)

[Solid Waste Information and Assessment Program - Reporting Table, Form DEQ 50-25 with Statement of Economic Benefits Form and Instructions \(rev. 11/2014\)](#)

~~[Solid Waste Annual Permit Fee Quarter Payment Form PF001 \(rev. 7/2015\)](#)~~

[Solid Waste Annual Permit Fee Quarter Payment Form PF001 \(rev. 8/2016\)](#)

VA.R. Doc. No. R17-4834; Filed August 30, 2016, 8:41 a.m.

STATE WATER CONTROL BOARD

Forms

REGISTRAR'S NOTICE: Forms used in administering the following regulation have been filed by the State Water Control Board. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

Title of Regulation: **9VAC25-610. Groundwater Withdrawal Regulations.**

Contact Information: Cindy M. Berndt, Director, Regulatory Affairs, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4378, FAX (804) 698-4019, or email cindy.berndt@deq.virginia.gov.

FORMS (9VAC25-610)

[Department of Environmental Quality Water Division Permit Application Fee Form \(rev. 10/2014\)](#)

[Application Instructions for Completing a Groundwater Withdrawal Permit Application \(rev. 11/2013\)](#)

[Application for a Groundwater Withdrawal Permit \(rev. 9/2012\)](#)

[Groundwater Withdrawal Permit - Change of Ownership Agreement Form \(rev. 11/2013\)](#)

[Uncontested Termination Agreement \(rev. 11/2013\)](#)

~~[Uniform Water Well Completion Report, Form GW-2 \(rev. 7/2015\)](#)~~

[Uniform Water Well Completion Report, Form GW-2 \(rev. 8/2016\)](#)

[Uniform Water Well Completion Report Well Abandonment Form, GW-5 \(rev. 8/2016\)](#)

[Public Notice Authorization Form - Authorization for Public Notice Billing to Groundwater Withdrawal Permit Applicant \(rev. 11/2013\)](#)

[Preapplication Meeting - Application for a Groundwater Withdrawal Permit \(rev. 9/2012\)](#)

[Local and Areawide Planning Requirements \(rev. 9/2012\)](#)

[Quarterly Groundwater Withdrawal Report \(rev. 11/2013\)](#)

[Mitigation Plan \(rev. 11/2013\)](#)

[Existing Users Groundwater Withdrawal Permit Application and Instructions \(eff. 2/2014\)](#)

VA.R. Doc. No. R17-4860; Filed August 30, 2016, 8:21 a.m.



TITLE 11. GAMING

VIRGINIA RACING COMMISSION

Final Regulation

REGISTRAR'S NOTICE: The Virginia Racing Commission is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 17 of the Code of Virginia when promulgating technical regulations regarding actual live horse racing at race meetings licensed by the commission.

Title of Regulation: **11VAC10-50. Racing Officials (amending 11VAC10-50-50).**

Statutory Authority: § 59.1-369 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: David S. Lermond, Jr., Regulatory Coordinator, Virginia Racing Commission, 5707 Huntsman Road, Suite 201-B, Richmond, VA 23250, telephone (804) 966-7404, or email david.lermond@vrc.virginia.gov.

Summary:

The amendment gives the stewards the authority to allow for horses not to be saddled in the paddock when deemed necessary, mainly due to safety concerns. This rule change was recommended by the Virginia Racing Commission's Racing Safety and Medication Committee.

11VAC10-50-50. Paddock judge.

The licensee shall appoint a qualified person to act as the paddock judge for the race meeting. The paddock judge shall have general supervision of the paddock and among the duties of the paddock judge are:

1. Assuring that horses are in the paddock at the time appointed by the stewards and reporting to the stewards those horses which are late to the paddock;
2. Assembling the horses and jockeys in the paddock no later than 15 minutes before the scheduled post time for each race;
3. Keeping a record of all equipment carried by all horses in all races and permitting no change in equipment unless authorized by the stewards;
4. Inspecting the leg bandages worn by horses and ordering the bandages removed or replaced as deemed appropriate;
5. Supervising the schooling of horses in the paddock with the prior permission of the stewards;
6. Supervising the farrier assigned to the paddock to ensure that the plating of each horse in each race is examined, determining whether the horse is properly shod, and making changes deemed necessary;
7. Excluding from the paddock all those persons who have no immediate business with the horses entered in a race and reporting rule violations in the paddock area to the stewards;

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8. Taking all measures to ensure that the saddling of all horses is orderly, open to public view unless permission to saddle horses elsewhere has been granted by the stewards, free from interference, and further assuring that the horses are mounted at the same time, and leave the paddock for the post parade in the proper sequence;
9. Permitting a horse to be excused from parading and instead permitting that the horse be led to the post, with the approval of the stewards;
10. Assuring that the horse displays the proper saddle cloth number and the jockey wears the proper number before leaving the paddock for the post parade;
11. Keeping a record of those horses accompanied to the post by pony riders; and
12. Checking out horses and drivers as they leave the paddock for warmups prior to racing and checking in their return to the paddock after the warmups for Standardbred race meetings.

VA.R. Doc. No. R17-4844; Filed August 23, 2016, 11:47 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Virginia Racing Commission is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 17 of the Code of Virginia when promulgating technical regulations regarding actual live horse racing at race meetings licensed by the commission.

Title of Regulation: 11VAC10-140. Flat Racing (amending 11VAC10-140-50).

Statutory Authority: § 59.1-369 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: David S. Lermond, Jr., Regulatory Coordinator, Virginia Racing Commission, 5707 Huntsman Road, Suite 201-B, Richmond, VA 23250, telephone (804) 966-7404, or email david.lermond@vrc.virginia.gov.

Summary:

The amendment gives the stewards the authority to allow for horses (plural) not to be saddled in the paddock when deemed necessary, mainly due to safety concerns. This rule change was recommended by the Virginia Racing Commission's Racing Safety and Medication Committee.

11VAC10-140-50. Saddling horses.

The trainer shall be responsible for the saddling of the horse, and in his absence, he must assign an assistant or substitute trainer to saddle each horse entered by him. All horses must be saddled in the paddock unless permission to saddle ~~a horse~~ horses elsewhere has been granted by the stewards.

VA.R. Doc. No. R17-4845; Filed August 23, 2016, 11:56 a.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Final Regulation

Titles of Regulations: 12VAC5-71. Regulations Governing Virginia Newborn Screening Services (amending 12VAC5-71-10, 12VAC5-71-30, 12VAC5-71-150; adding 12VAC5-71-210 through 12VAC5-71-260).

12VAC5-191. State Plan for the Children with Special Health Care Needs Program (amending 12VAC5-191-260).

Statutory Authority: §§ 32.1-12 and 32.1-67 of the Code of Virginia.

Effective Date: October 20, 2016.

Agency Contact: Dev Nair, Director, Division of Policy and Evaluation, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7662, FAX (804) 864-7647, or email dev.nair@vdh.virginia.gov.

Summary:

The amendments require hospitals with a newborn nursery to screen all infants born in Virginia for critical congenital heart disease (CCHD) within 24 to 48 hours after birth using pulse oximetry. The amendments (i) require that hospitals develop protocols for screening, timely evaluation, and timely referral of newborns with abnormal screening results; (ii) require that a licensed practitioner perform the screening; (iii) establish when the screening is to occur, and if screening is not indicated, documentation requirements for the medical record; (iv) require hospitals to develop screening protocols for specialty and subspecialty nurseries; (v) require that all screening results are entered into the medical record and the electronic birth certificate system, and that health care providers report abnormal screening results immediately; (vi) prohibit the discharge of a newborn with an abnormal screen until the cause of the abnormal screen has been evaluated and an appropriate plan for care is in place; (vii) require that hospitals report individuals diagnosed with CCHD to the department for referral to care coordination services through the Care Connection for Children; (viii) specify documents that must be provided in response to a request by the department's VaCARES system and the confidentiality rules for these documents; and (ix) permit parents to refuse CCHD screening based upon religious practices or tenets and specify that the hospital must report the refusal to the department.

This regulatory action also includes amendments to the State Plan for the Children with Special Health Care Needs Program (12VAC5-191), so that those regulations remain consistent with 12VAC5-71.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's

response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

12VAC5-71-10. Definitions.

The following words and terms when used in this ~~regulation~~ chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abnormal screening results" means, in 12VAC5-71-210 through 12VAC5-71-250 only, all results that indicate the newborn has not passed the [CCHD] screening [test].

"Attending physician" means the physician in charge of the infant's care.

"Board" means the State Board of Health.

"Business days" means Monday through Friday from 9 a.m. to 5 p.m., excluding federal and state holidays.

"Care Connection for Children" means a statewide network of centers of excellence for children with special health care needs (CSHCN) that provides leadership in the enhancement of specialty medical services, care coordination, medical insurance benefits evaluation and coordination, management of the CSHCN pool of funds, information and referral to CSHCN resources, family-to-family support, and training and consultation with community providers on CSHCN issues.

"Care coordination" means a process that links individuals and their families to services and resources in a coordinated effort to maximize their potential and provide them with optimal health care.

"Certified nurse midwife" means a person licensed to practice as a nurse practitioner in the Commonwealth pursuant to § 54.1-2957 of the Code of Virginia and in accordance with Part II (18VAC90-30-60 et seq.) of 18VAC90-30 and 18VAC90-30-121, subject to 18VAC90-30-160.

"Chief executive officer" means a job descriptive term used to identify the individual appointed by the governing body to act in its behalf in the overall management of the hospital. Job titles may include administrator, superintendent, director, executive director, president, vice-president, and executive vice-president.

"Child" means a person less than 18 years of age and includes a biological or an adopted child, as well as a child placed for adoption or foster care unless otherwise treated as a separate unit for the purposes of determining eligibility and charges under these regulations.

"Commissioner" means the State Health Commissioner, his duly designated officer, or agent.

"Confirmatory testing" means a test or a panel of tests performed following a screened-abnormal result to verify a diagnosis.

"Core panel conditions" means those heritable disorders and genetic diseases considered appropriate for newborn screening. The conditions in the core panel are similar in that they have (i) specific and sensitive screening tests, (iii) a

sufficiently well understood natural history, and (iii) available and efficacious treatments.

"Critical congenital heart disease" or "CCHD" means a congenital heart disease that places a newborn at significant risk of disability or death if not diagnosed and treated soon after birth. The disease may include, but is not limited to, hypoplastic left heart syndrome, pulmonary atresia (with intact septum), tetralogy of fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus.

"CCHD screening" means the application of screening technology to detect CCHD.

"Department" means the state Department of Health.

"Dried-blood-spot specimen" means a clinical blood sample collected from an infant by heel stick method and placed directly onto specially manufactured absorbent specimen collection (filter) paper.

"Echocardiogram" means a test that uses an ultrasound to provide an image of the heart.

"Guardian" means a parent-appointed, court-appointed, or clerk-appointed guardian of the person.

"Healthcare provider" means a person who is licensed to provide health care as part of his job responsibilities and who has the authority to order newborn dried-blood-spot screening tests.

"Heritable disorders and genetic diseases" means pathological conditions (i.e., interruption, cessation or disorder of body functions, systems, or organs) that are caused by an absent or defective gene or gene product, or by a chromosomal aberration.

"Hospital" means any facility as defined in § 32.1-123 of the Code of Virginia.

"Infant" means a child less than 12 months of age.

"Licensed practitioner" means a licensed health care provider who is permitted, within the scope of his practice pursuant to Chapter 29 (§ 54.1-2900 et seq.) or Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, to provide care to a newborn.

"Low protein modified foods" means foods that are (i) specially formulated to have less than one gram of protein per serving, (ii) intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, (iii) not natural foods that are naturally low in protein, and (iv) prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases.

"Metabolic formula" means nutritional substances that are (i) prescribed by a health professional with appropriate prescriptive authority; (ii) specifically designed and formulated to be consumed or administered internally under the supervision of such health professional; (iii) specifically designed, processed, or formulated to be distinct in one or more nutrients that are present in natural food; and (iv)

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intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or limited capacity to metabolize certain nutrients contained in ordinary foodstuffs.

"Metabolic supplements" means certain dietary or nutritional substances intended to be used under the direction of a physician for the nutritional management of inherited metabolic diseases.

"Midwife" means a person licensed as a nurse practitioner in the category of certified nurse midwife by the Boards of Nursing and Medicine or licensed as a midwife by the Board of Medicine.

"Newborn" means an infant who is 28 days old or less who was born in Virginia.

"Newborn nursery" means a general level, intermediate level, or specialty level newborn service as defined in 12VAC5-410-443 B 1, B 2, and B 3.

"Nurse" means a person holding a current license as a registered nurse or licensed practical nurse by the Virginia Board of Nursing or a current multistate licensure privilege to practice in Virginia as a registered nurse or licensed practical nurse.

"Parent" means a biological parent, adoptive parent, or stepparent.

"Pediatric Comprehensive Sickle Cell Clinic Network" means a statewide network of clinics that are located in major medical centers and provide comprehensive medical and support services for newborns and children living with sickle cell disease and other genetically related hemoglobinopathies.

"Physician" means a person licensed to practice medicine or osteopathic medicine in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1 of the Code of Virginia and in accordance with applicable regulations.

"Pool of funds" means funds designated for payment of direct health care services. Access to the pool is not an entitlement and is subject to availability of funds and guidelines that govern its eligibility and coverage of services. Pool of funds is a mix of federal Title V funds and state matching funds.

"Population-based" means preventive interventions and personal health services developed and available for the entire infant and child health population of the Commonwealth rather than for individuals in a one-on-one situation.

"Preterm infant" means an infant whose birth occurs by the end of the last day of the 36th week following the onset of the last menstrual period.

"Repeat specimen" means an additional newborn dried-blood-spot screening specimen submitted to the testing laboratory voluntarily or by request.

"Resident" means an individual who resides within the geographical boundaries of the Commonwealth.

"Satisfactory specimen" means a newborn dried-blood-spot screening specimen that has been determined to be acceptable for laboratory analyses by the testing laboratory.

"Screened-abnormal" means a newborn dried-blood-spot screening test result that is outside the established normal range or normal value for that test method.

"Screening technology" means pulse oximetry testing in the right hand and either foot. Screening technology shall also include alternate medically accepted tests that measure the percentage of blood oxygen saturation, follow medical guideline consensus and recommendations issued by the American Academy of Pediatrics, and are approved by the State Board of Health.

"Specialty level nursery" means the same as defined in 12VAC5-410-443 B 3 and as further defined as Level III by the Levels of Neonatal Care, written by the American Academy of Pediatrics Committee on Fetus and Newborn.

"Subspecialty level nursery" means the same as defined in 12VAC5-410-443 B 4.

"Testing laboratory" means the laboratory that has been selected by the department to perform newborn dried-blood-spot screening tests services.

"Total parenteral nutrition" or "TPN" means giving nutrients through a vein for babies who cannot be fed by mouth.

"Treatment" means appropriate management including genetic counseling, medical consultation, and pharmacological and dietary management for infants diagnosed with a disease listed in 12VAC5-71-30 D.

"Unsatisfactory specimen" means a newborn dried-blood-spot screening specimen that is inadequate for performing an accurate analysis.

"Virginia Genetics Advisory Committee" means a formal group that advises the department on issues pertaining to access to clinical genetics services across the Commonwealth and the provision of genetic awareness, quality services, and education for consumers and providers.

"Virginia Newborn Screening System" means a coordinated and comprehensive group of services, including education, screening, follow up, diagnosis, treatment and management, and program evaluation, managed by the department's Virginia Newborn Screening Program and Virginia Early Hearing Detection and Intervention Program for safeguarding the health of children born in Virginia.

"Virginia Sickle Cell Awareness Program" means a statewide program for the education and screening of individuals for the disease of sickle cell anemia or the sickle cell trait and for such other genetically related hemoglobinopathies.

12VAC5-71-30. Core panel of heritable disorders and genetic diseases.

A. The Virginia Newborn Screening System, which includes the Virginia Newborn Screening Program and the Virginia

Early Hearing Detection and Intervention Program, and [the] Virginia critical congenital heart disease screening, shall ensure that the core panel of heritable disorders and genetic diseases for which newborn screening is conducted is consistent with but not necessarily identical to the U.S. Department of Health and Human Services Secretary's Recommended Uniform Screening Panel.

B. The department shall review, at least biennially, national recommendations and guidelines and may propose changes to the core panel of heritable disorders and genetic diseases for which newborn dried-blood-spot screening tests are conducted.

C. The Virginia Genetics Advisory Committee may be consulted and provide advice to the commissioner on proposed changes to the core panel of heritable disorders and genetic diseases for which newborn dried-blood-spot screening tests are conducted.

D. Infants under six months of age who are born in Virginia shall be screened in accordance with the provisions set forth in this chapter for the following heritable disorders and genetic diseases, which are identified through newborn dried-blood-spot screening tests:

1. Argininosuccinic aciduria (ASA);
2. Beta-Ketothiolase deficiency (BKT);
3. Biotinidase deficiency (BIOT);
4. Carnitine uptake defect (CUD);
5. Classical galactosemia (galactose-1-phosphate uridylyltransferase deficiency) (GALT);
6. Citrullinemia type I (CIT-I);
7. Congenital adrenal hyperplasia (CAH);
8. Cystic fibrosis (CF);
9. Glutaric acidemia type I (GA I);
10. Hb S beta-thalassemia (Hb F,S,A);
11. Hb SC-disease (Hb F,S,C);
12. Hb SS-disease (sickle cell anemia) (Hb F, S);
13. Homocystinuria (HCY);
14. Isovaleric acidemia (IVA);
15. Long chain L-3-Hydroxy acyl-CoA dehydrogenase deficiency (LCHAD);
16. Maple syrup urine disease (MSUD);
17. Medium-chain acyl-CoA dehydrogenase deficiency (MCAD);
18. Methylmalonic acidemia (Methylmalonyl-CoA mutase deficiency) (MUT);
19. Methylmalonic acidemia (Adenosylcobalamin synthesis deficiency) (CBL A, CBL B);
20. Multiple carboxylase deficiency (MCD);
21. Phenylketonuria (PKU);
22. Primary congenital hypothyroidism (CH);

23. Propionic acidemia (PROP);
24. Severe combined immunodeficiency (SCID);
25. Tyrosinemia type I (TYR I);
26. Trifunctional protein deficiency (TFP);
27. Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD);
28. 3-hydroxy 3-methyl glutaric aciduria (HMG); and
29. 3-Methylcrotonyl-CoA carboxylase deficiency (3-MCC).

E. Infants born in Virginia shall be screened for hearing loss in accordance with provisions set forth in §§ 32.1-64.1 and 32.1-64.2 of the Code of Virginia and as governed by 12VAC5-80.

F. Newborns born in Virginia shall be screened for critical congenital heart disease in accordance with provisions set forth in §§ 32.1-65.1 and 32.1-67 of the Code of Virginia and as governed by 12VAC5-71-210 through 12VAC5-71-260.

12VAC5-71-150. Responsibilities of the Care Connection for Children network.

A. The Care Connection for Children network shall provide the following services:

1. Care coordination services for residents of the Commonwealth who are diagnosed with selected heritable disorders or genetic diseases, or critical congenital heart disease and are referred to the network by the Virginia Newborn Screening Program.
2. Other network services for eligible individuals in accordance with ~~the~~ § 32.1-77 of the Code of Virginia and applicable regulations.

B. The Care Connection for Children network shall provide data as needed by the department's newborn screening program.

12VAC5-71-210. Critical congenital heart disease screening protocols.

A. Hospitals shall develop protocols for critical congenital heart disease screening [(i)] in accordance with [~~this section~~] 12VAC5-71-220 through 12VAC5-71-260 [;] and [(ii) modeled after] national recommendations from the American Academy of Pediatrics [regarding CCHD, such as those specified in Strategies for Implementing Screening for Critical Congenital Heart Disease (Kemper et al., Pediatrics, November 2011, Volume 128, Issue 5 (2011 Nov;128(5):e1259-67) and Implementing Recommended Screening for Critical Congenital Heart Disease (Martin et al., Pediatrics, 2013, Volume 132, Issue 1 (2013 Jul;132(1):e185-92) and subsequent revisions and editions].

B. Hospitals shall develop protocols for the physical evaluation by licensed practitioners of newborns with abnormal screening results.

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C. Hospitals shall develop protocols for the referral of newborns with abnormal screening results, if needed, after evaluation.

12VAC5-71-220. Critical congenital heart disease screening.

A. A licensed practitioner shall perform the CCHD screening.

B. Except as specified in subsection C of this section and 12VAC5-71-260, CCHD screening [using pulse oximetry] shall be performed on every newborn in the birth hospital between 24 and 48 hours of life, or if the newborn is discharged from the hospital before reaching 24 hours of life, the CCHD screening shall be performed as late as practical before discharge.

C. If CCHD screening [using pulse oximetry] is not [indicated performed], the reason shall be documented in the newborn's medical record. The reasons include but are not limited to:

1. The newborn's current clinical evaluation has included an echocardiogram that ruled out CCHD;
2. The newborn has confirmed CCHD; [~~or~~]
3. The newborn is under the care of a specialty level or subspecialty level nursery [, in which case the screening shall be performed in accordance with the protocols developed in subsection D of this section; or
4. The parent or guardian refuses CCHD screening on the basis of religious practices or tenets pursuant to 12VAC5-71-260].

D. Hospitals shall develop protocols for screening newborns in specialty level nurseries and subspecialty level nurseries.

12VAC5-71-230. Critical congenital heart disease screening results.

A. Recording results.

1. All CCHD screening results shall be recorded in the newborn's medical record.
2. All CCHD screening results shall be entered into the electronic birth certificate system with the following information:
 - a. CCHD screening completed, CCHD pass or fail, and pulse oximetry values [, if applicable]; or
 - b. Not screened pursuant to 12VAC5-71-220 C [4].

B. Abnormal screening results.

1. Abnormal screening results shall be reported by the authorized health care provider who conducted the screening to the attending physician or his designee [immediately].
2. A newborn shall be evaluated by an attending physician or his designee according to the timeframes within the hospital protocol developed in accordance with 12VAC5-71-210.
3. A newborn shall not be discharged from care until:

a. A cause for the abnormal screening result has been determined and a plan is in place for immediate evaluation at another medical facility; or

b. An echocardiogram has been performed and read, and an appropriate clinical plan has been developed.

4. Any diagnosis arising from abnormal screening results shall be entered into the electronic birth certificate system.

5. The attending physician or his designee shall provide notification of abnormal [screening] results and any diagnoses to the newborn's parent or guardian and to the primary care provider in charge of the newborn's care after the newborn leaves the hospital.

12VAC5-71-240. Referral for care coordination.

A. For any person diagnosed under 12VAC5-71-210 through 12VAC5-71-250, the chief administrative officer of every hospital, as defined in § 32.1-123 of the Code of Virginia, shall make or cause to be made a report to the commissioner in accordance with § 32.1-69.1 of the Code of Virginia.

B. Upon receiving the notification described in subsection A of this section, the Newborn Screening Program at the Virginia Department of Health shall refer the newborn's parent or guardian to the Care Connection for Children network for care coordination services.

12VAC5-71-250. Congenital heart disease screening records.

A. The screening of newborns pursuant to this chapter is a population-based public health surveillance program as defined by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033).

B. Upon request, a hospital shall make available to the Virginia Congenital Anomalies Reporting and Education System (VaCARES):

1. Medical records;
2. Records of laboratory tests; and
3. Any other information that VaCARES considers necessary to:
 - a. Determine final outcomes of abnormal CCHD screening results; or
 - b. Evaluate CCHD screening activities in the Commonwealth, including performance of follow-up evaluations and diagnostic tests, initiation of treatment when necessary, and surveillance of the accuracy and efficacy of the [CCHD] screening.

C. Information that the Virginia Department of Health receives under this section is confidential and may only be used or disclosed:

1. For research and collective statistical purposes pursuant to § 32.1-67.1 of the Code of Virginia;
2. For state or federally mandated statistical reports;

3. To ensure that the information received by the Virginia Department of Health is accurate and reliable; or

4. For reporting to the Virginia Congenital Anomalies Reporting and Education System pursuant to § 32.1-69.1 of the Code of Virginia and 12VAC5-191-280. The Newborn Screening Program shall refer the newborn's parent or guardian to the Care Connection for Children network for care coordination services.

D. The hospital administrator shall ensure that CCHD screening is included in the perinatal quality assurance program and provide the results of the quality improvement program to the Virginia Department of Health upon request.

12VAC5-71-260. Parent or guardian refusal for screening.

A. In the instance of parent or guardian refusal of the CCHD screening based on religious practices or tenets, the parent or guardian refusal shall be documented on a refusal form provided by the Virginia Department of Health and made a part of the newborn's medical record.

B. The administrator of the hospital shall ensure that the Newborn Screening Program at the Virginia Department of Health is notified in writing of the parent or guardian refusal within five days of the newborn's birth.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC5-71)

[~~Notification of Parental Refusal of Dried Blood Spot and Critical Congenital Heart Disease Screening (undated)~~

[Notification of Parental Refusal of Dried-Blood Spot and Critical Congenital Heart Disease Screening \(rev. 4/2015\)](#)]

DOCUMENTS INCORPORATED BY REFERENCE (12VAC5-71)

[Levels of Neonatal Care, Policy Statement from Committee on Fetus and Newborn, American Academy of Pediatrics, August 27, 2012](#)

12VAC5-191-260. Scope and content of the Virginia Newborn Screening System.

A. The Virginia Newborn Screening System consists of ~~two~~ three components: (i) Virginia Newborn Screening Services ~~and~~, (ii) Virginia Early Hearing Detection and Intervention Program, and (iii) Virginia critical congenital heart disease screening.

B. Virginia Newborn Screening Services.

1. Mission. The Virginia Newborn Screening Services prevents ~~mental retardation~~ intellectual disability, permanent disability, or death through early identification

and treatment of infants who are affected by selected inherited disorders.

2. Scope of services. The Virginia Newborn Screening Services provides a coordinated and comprehensive system of services to assure that all infants receive a screening test after birth for selected inherited metabolic, endocrine, and hematological disorders as defined in Regulations Governing ~~the Virginia Newborn Screening and Treatment Program Services, 12VAC5-70~~ 12VAC5-71.

These population-based, direct, and enabling services are provided through:

- a. Biochemical dried bloodspot screening tests.
- b. Follow up of abnormal results.
- c. Diagnosis.
- d. Education to health professionals and families.
- e. Expert consultation on abnormal results, diagnostic testing, and medical and dietary management for health professionals.

Medical and dietary management is provided for the diagnosed cases and includes assistance in accessing specialty medical services and referral to Care Connection for Children.

The screening and management for specified diseases are governed by Regulations Governing ~~the Virginia Newborn Screening and Treatment Program Services, 12VAC5-70~~ 12VAC5-71.

3. Criteria to receive Virginia Newborn Screening Services. All infants born in the Commonwealth are eligible for the screening test for selected inherited disorders.

4. Goal. The Title V national performance measures, as required by the federal Government Performance and Results Act (~~GPR~~ Pub. L. [Public Law (P.L.] 103-62), are used to establish the program goals. The following goal shall change as needed to be consistent with the Title V national performance measures:

All infants will receive appropriate newborn bloodspot screening, follow up testing, and referral to services.

C. Virginia Early Hearing Detection and Intervention Program.

1. Mission. The Virginia Early Hearing Detection and Intervention Program promotes early detection of and intervention for infants with congenital hearing loss to maximize linguistic and communicative competence and literacy development.

2. Scope of services. The Virginia Early Hearing Detection and Intervention Program provides services to assure that all infants receive a hearing screening after birth, that infants needing further testing are referred to appropriate facilities, that families have the information that they need to make decisions for their children, and that infants and young children diagnosed with a hearing loss receive

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appropriate and timely intervention services. These population-based and enabling services are provided through:

- a. Technical assistance and education to new parents.
- b. Collaboration with physicians and primary care providers.
- c. Technical assistance and education to birthing facilities and those persons performing home births.
- d. Collaboration with audiologists.
- e. Education to health professionals and general public.

Once diagnosed, the infants are referred to early intervention services. The screening and management for hearing loss are governed by the regulation, Regulations for Administration of the Virginia Hearing Impairment Identification and Monitoring System, 12VAC5-80.

3. Criteria to receive services from the Virginia Early Hearing Detection and Intervention Program.

- a. All infants born in the Commonwealth are eligible for the hearing screening.
- b. All infants who are residents of the Commonwealth and their families are eligible for the Virginia Early Hearing Detection and Intervention Program.

4. Goals. The Title V national performance measures, as required by the federal Government Performance and Results Act (GPRA Pub. L. [~~(Public Law (P.L.)~~ 103-62), are used to establish the program goals. The following goals shall change as needed to be consistent with the Title V national performance measures:

All infants will receive screening for hearing loss no later than one month of age, achieve identification of congenital hearing loss by three months of age, and enroll in appropriate intervention by six months of age.

D. Virginia critical congenital heart disease screening.

1. Mission. Virginia critical congenital heart disease screening promotes early detection of and intervention for newborns with critical congenital heart disease to maximize positive health outcomes and help prevent disability and death early in life.

2. Scope of services. Newborns receive a critical congenital heart disease screening 24 to 48 hours after birth in a hospital with a newborn nursery, as provided in §§ [32.1-65.1 and] 32.1-67 [~~and 32.1-69.1~~] of the Code of Virginia and the regulations governing critical congenital heart disease screening (12VAC5-71-210 through 12VAC5-71-260). These population-based, direct, and enabling services are provided through:

- a. Critical congenital heart disease screening tests using pulse oximetry or other screening technology as defined in 12VAC5-71-10;

b. Hospital reporting of test results pursuant to § 32.1-69.1 of the Code of Virginia and [~~12VAC5-191-280~~ 12VAC5-71-240]; and

c. Follow-up, referral processes, and services, as appropriate, through Care Connection for Children.

3. The screening and management for newborn critical congenital heart disease are governed by [~~the regulations governing critical congenital heart disease screening (12VAC5-71-210 through 12VAC5-71-260)~~ 12VAC5-71-210 through 12VAC5-71-260 of the Regulations Governing Virginia Newborn Screening Services].

4. Criteria to receive critical congenital heart disease screening. Except as specified in 12VAC5-71-220 C and 12VAC5-71-260, all newborns born in the Commonwealth in a hospital with a newborn nursery shall receive the screening test for critical congenital heart disease 24 to 48 hours after birth using pulse oximetry or other screening technology.

5. Goal. Except as specified in 12VAC5-71-220 C and 12VAC5-71-260, all newborns born in the Commonwealth in a hospital with a newborn nursery shall receive appropriate critical congenital heart disease screening 24 to 48 hours after birth.

VA.R. Doc. No. R15-4176; Filed August 19, 2016, 3:16 p.m.

Final Regulation

Title of Regulation: 12VAC5-90. Regulations for Disease Reporting and Control (amending 12VAC5-90-10, 12VAC5-90-80, 12VAC5-90-90, 12VAC5-90-100, 12VAC5-90-110, 12VAC5-90-280; repealing 12VAC5-90-50, 12VAC5-90-290 through 12VAC5-90-360).

Statutory Authority: § 32.1-35 of the Code of Virginia.

Effective Date: October 20, 2016.

Agency Contact: Diane Woolard, Ph.D., Director, Division of Surveillance and Investigation, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-8124, or email diane.woolard@vdh.virginia.gov.

Summary:

The amendments (i) update the reportable disease list to reflect current national recommendations and language; (ii) update the list of conditions reportable by laboratory directors to reflect current laboratory technology and public health standards; (iii) increase the information reported by laboratory directors for hepatitis B and human immunodeficiency virus testing and the specimens to be submitted to the Division of Consolidated Laboratory Services or other laboratory designated by the agency for advanced laboratory testing; (iv) clarify agency role in interstate and national notifications; (v) clarify level of information that may be shared with the agency by schools and other facilities; and (vi) update reporting of dangerous microbes and pathogens sections to reflect federal code section numbering changes and other requirements.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Part I
Definitions

12VAC5-90-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

~~["Acute care hospital" means a hospital as defined in § 32.1-123 of the Code of Virginia that provides medical treatment for patients having an acute illness or injury or recovering from surgery.~~

~~"Adult intensive care unit" means a nursing care area that provides intensive observation, diagnosis, and therapeutic procedures for persons 18 years of age or more who are critically ill. Such units may also provide intensive care to pediatric patients. An intensive care unit excludes nursing areas that provide step-down, intermediate care, or telemetry only.~~

"Affected area" means any part or the whole of the Commonwealth, which has been identified as where persons reside, or may be located, who are known to have been exposed to or infected with, or who are reasonably suspected to have been exposed to or infected with, a communicable disease of public health threat. "Affected area" shall include, but not be limited to, cities, counties, towns, and subsections of such areas, public and private property, buildings, and other structures.

"Arboviral infection" means a viral illness that is transmitted by a mosquito, tick, or other arthropod. This includes, but is not limited to, chikungunya [(CHIK)], dengue, eastern equine encephalitis (EEE), LaCrosse encephalitis (LAC) [, also known as California encephalitis], St. Louis encephalitis (SLE), [~~and~~] West Nile virus (WNV) [, and Zika virus (Zika)] infection.

"Board" means the State Board of Health.

"Cancer" means all carcinomas, sarcomas, melanomas, leukemias, and lymphomas excluding localized basal and squamous cell carcinomas of the skin, except for lesions of the mucous membranes.

"CDC" means the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.

~~["Central line associated bloodstream infection" means a primary bloodstream infection identified by laboratory tests, with or without clinical signs or symptoms, in a patient with a central line device, and meeting the current] Centers for Disease Control and Prevention (CDC) [CDC surveillance definition for laboratory confirmed primary bloodstream infection.~~

~~"Central line device" means a vascular infusion device that terminates at or close to the heart or in one of the] greater [great vessels. The following are considered great vessels for the purpose of reporting central line infections and counting central line days: aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, and common femoral veins.]~~

"Child care center" means a child day center, child day program, family day home, family day system, or registered family day home as defined by § 63.2-100 of the Code of Virginia, or a similar place providing day care of children by such other name as may be applied.

"Clinic" means any facility, freestanding or associated with a hospital, that provides preventive, diagnostic, therapeutic, rehabilitative, or palliative care or services to outpatients.

"Commissioner" means the State Health Commissioner or his duly designated officer or agent, unless stated in a provision of [~~these regulations~~ this chapter] that it applies to the State Health Commissioner in his sole discretion.

"Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted, directly or indirectly, to a susceptible host from an infected person, animal, or arthropod or through the agency of an intermediate host or a vector or through the inanimate environment.

"Communicable disease of public health significance" means an illness caused by a specific or suspected infectious agent that may be transmitted directly or indirectly from one individual to another. This includes but is not limited to infections caused by human immunodeficiency viruses, bloodborne pathogens, and tubercle bacillus. The State Health Commissioner may determine that diseases caused by other pathogens constitute communicable diseases of public health significance.

"Communicable disease of public health threat" means an illness of public health significance, as determined by the State Health Commissioner in accordance with [~~these regulations~~ this chapter], caused by a specific or suspected infectious agent that may be reasonably expected or is known to be readily transmitted directly or indirectly from one individual to another and has been found to create a risk of death or significant injury or impairment; this definition shall not, however, be construed to include human immunodeficiency viruses or the tubercle bacilli, unless used as a bioterrorism weapon.

"Companion animal" means [, consistent with the provisions of § 3.2-6500 of the Code of Virginia,] any domestic or feral dog, domestic or feral cat, nonhuman primate, guinea pig, hamster, rabbit not raised for human food or fiber, exotic or native animal, reptile, exotic or native bird, or any feral animal or any animal under the care, custody, or ownership of a person or any animal that is bought, sold, traded, or bartered by any person. Agricultural animals, game

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species, or any animals regulated under federal law as research animals shall not be considered companion animals for the purpose of this [regulation chapter].

"Condition" means any adverse health event, such as a disease, an infection, a syndrome, or as indicated by a procedure (including but not limited to the results of a physical exam, laboratory test, or imaging interpretation) suggesting that an exposure of public health importance has occurred.

"Contact" means a person or animal known to have been in such association with an infected person or animal as to have had an opportunity of acquiring the infection.

"Contact services" means a broad array of services that are offered to persons with infectious diseases and their contacts. Contact services include contact tracing, providing information about current infections, developing risk reduction plans to reduce the chances of future infections, and connecting to appropriate medical care and other services.

"Contact tracing" means the process by which an infected person or health department employee notifies others that they may have been exposed to the infected person in a manner known to transmit the infectious agent in question.

["Coronavirus infection, severe" means suspected or confirmed infection with severe acute respiratory syndrome (SARS)-associated coronavirus (SARS-CoV), Middle East respiratory syndrome (MERS)-associated coronavirus (MERS-CoV), or another coronavirus causing a severe acute illness.]

"Decontamination" means the use of physical or chemical means to remove, inactivate, or destroy hazardous substances or organisms from a person, surface, or item to the point that such substances or organisms are no longer capable of causing adverse health effects and the surface or item is rendered safe for handling, use, or disposal.

"Department" means the State Department of Health [, also referred to as the Virginia Department of Health (VDH)].

"Designee" or "designated officer or agent" means any person, or group of persons, designated by the State Health Commissioner, to act on behalf of the commissioner or the board.

~~"Ehrlichiosis/anaplasmosis"~~ "Ehrlichiosis/Anaplasmosis" means human infections caused by Ehrlichia chaffeensis (formerly included in the category "human monocytic ehrlichiosis" or "HME"), Ehrlichia ewingii or Anaplasma phagocytophilum (formerly included in the category "human granulocytic ehrlichiosis" or "HGE").

"Epidemic" means the occurrence in a community or region of cases of an illness clearly in excess of normal expectancy.

"Essential needs" means basic human needs for sustenance including but not limited to food, water, [clothing,] and health care; (e.g., medications, therapies, testing, and durable medical equipment).

"Exceptional circumstances" means the presence, as determined by the commissioner in his sole discretion, of one or more factors that may affect the ability of the department to effectively control a communicable disease of public health threat. Factors to be considered include but are not limited to: (i) characteristics or suspected characteristics of the disease-causing organism or suspected disease-causing organism such as virulence, routes of transmission, minimum infectious dose, rapidity of disease spread, the potential for extensive disease spread, and the existence and availability of demonstrated effective treatment; (ii) known or suspected risk factors for infection; (iii) the potential magnitude of the effect of the disease on the health and welfare of the public; and (iv) the extent of voluntary compliance with public health recommendations. The determination of exceptional circumstances by the commissioner may take into account the experience or results of investigation in Virginia, another state, or another country.

"Foodborne outbreak" means two or more cases of a similar illness acquired through the consumption of food contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to heavy metal intoxication, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens food poisoning, hepatitis A, and Shiga toxin-producing Escherichia coli O157:H7 infection.

"Healthcare-associated infection" (also known as nosocomial infection) means a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent or agents or its toxin or toxins that (i) occurs in a patient in a ~~healthcare~~ health care setting (e.g., a hospital or outpatient clinic), (ii) was not found to be present or incubating at the time of admission unless the infection was related to a previous admission to the same setting, and (iii) if the setting is a hospital, meets the criteria for a specific infection site as defined by CDC.

"Hepatitis C, acute" means the following clinical characteristics are met: (i) discrete onset of symptoms indicative of viral hepatitis and (ii) jaundice or elevated serum aminotransferase levels and the following laboratory criteria are met: (a) serum alanine aminotransferase levels (ALT) greater than [~~400~~ 200] IU/L; (b) IgM anti-HAV negative (if done); (c) IgM anti-HBc negative (if done); and (d) hepatitis C virus antibody (anti-HCV) [~~screening test~~] positive [~~with a signal to cutoff ratio predictive of a true positive as determined for the particular assay as defined by CDC, HCV antibody positive by immunoblot (RIBA)~~], [HCV antigen positive,] or HCV RNA positive by nucleic acid test.

"Hepatitis C, chronic" means that the laboratory criteria specified in clauses (b), (c) and (d) listed above for an acute case are met but clinical signs or symptoms of acute viral hepatitis are not present and serum alanine aminotransferase (ALT) levels do not exceed [~~400~~ 200] IU/L. This category

will include cases that may be acutely infected but not symptomatic.

"Immunization" means a procedure that increases the protective response of an individual's immune system to specified pathogens.

"Independent pathology laboratory" means a nonhospital or a hospital laboratory performing surgical pathology, including fine needle aspiration biopsy and bone marrow specimen examination services, which reports the results of such tests directly to physician offices, without reporting to a hospital or accessioning the information into a hospital tumor registry.

"Individual" means a person or companion animal. When the context requires it, "person or persons" shall be deemed to include any individual.

"Infection" means the entry and multiplication or persistence of a disease-causing organism (prion, virus, bacteria, fungus, parasite, or ectoparasite) in the body of an individual. An infection may be inapparent (i.e., without recognizable signs or symptoms but identifiable by laboratory means) or manifest (clinically apparent).

"Influenza A, novel virus" means infection of a human with an influenza A virus subtype that is different from currently circulating human influenza H1 and H3 viruses. Novel subtypes include H2, H5, H7, and H9 subtypes or influenza H1 and H3 subtypes originating from a nonhuman species.

"Invasive" means the organism is affecting a normally sterile site, including but not limited to blood or cerebrospinal fluid.

"Investigation" means an inquiry into the incidence, prevalence, extent, source, mode of transmission, causation of, and other information pertinent to a disease occurrence.

"Isolation" means the physical separation, including confinement or restriction of movement, of an individual or individuals who are infected with, or are reasonably suspected to be infected with, a communicable disease in order to prevent or limit the transmission of the communicable disease to uninfected and unexposed individuals.

"Isolation, complete" means the full-time confinement or restriction of movement of an individual or individuals infected with, or reasonably suspected to be infected with, a communicable disease in order to prevent or limit the transmission of the communicable disease to uninfected and unexposed individuals.

"Isolation, modified" means a selective, partial limitation of freedom of movement or actions of an individual or individuals infected with, or reasonably suspected to be infected with, a communicable disease. Modified isolation is designed to meet particular situations and includes but is not limited to the exclusion of children from school, the prohibition or restriction from engaging in a particular occupation or using public or mass transportation, or

requirements for the use of devices or procedures intended to limit disease transmission.

"Isolation, protective" means the physical separation of a susceptible individual or individuals not infected with, or not reasonably suspected to be infected with, a communicable disease from an environment where transmission is occurring, or is reasonably suspected to be occurring, in order to prevent the individual or individuals from acquiring the communicable disease.

"Laboratory" as used herein means a clinical laboratory that examines materials derived from the human body for the purpose of providing information on the diagnosis, prevention, or treatment of disease.

"Laboratory director" means any person in charge of supervising a laboratory conducting business in the Commonwealth of Virginia.

"Law-enforcement agency" means any sheriff's office, police department, adult or youth correctional officer, or other agency or department that employs persons who have law-enforcement authority that is under the direction and control of the Commonwealth or any local governing body. "Law-enforcement agency" shall include, by order of the Governor, the Virginia National Guard.

~~["Lead, elevated blood levels" means a confirmed blood level greater than or equal to] 10 micrograms of lead per deciliter (µg/dL) of whole blood in a child or children 15 years of age and younger, a venous blood lead level greater than or equal to 25 µg/dL in a person older than 15 years of age, or such lower blood lead level as may be recommended for individual intervention by the department or the Centers for Disease Control and Prevention [the reference value established by the CDC. In 2012, the reference value was 5 µg/dL in children and 10 µg/dL for persons "Lead, reportable levels" means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person] older than 15 years of age.~~

"Least restrictive" means the minimal limitation of the freedom of movement and communication of an individual while under an order of isolation or an order of quarantine that also effectively protects unexposed and susceptible individuals from disease transmission.

"Medical care facility" means any hospital or nursing home licensed in the Commonwealth, or any hospital operated by or contracted to operate by an entity of the United States government or the Commonwealth of Virginia.

"Midwife" means any person who is licensed as a nurse midwife by the Virginia Boards of Nursing and Medicine or who is licensed by the Board of Medicine as a certified professional midwife.

"National Healthcare Safety Network (NHSN)" or "NHSN" means a surveillance system created by the CDC for accumulating, exchanging, and integrating relevant

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information on infectious adverse events associated with ~~healthcare~~ health care delivery.

"Nucleic acid detection" means laboratory testing of a clinical specimen to determine the presence of deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) specific for an infectious agent using any method, including hybridization, sequencing, or amplification such as polymerase chain reaction.

"Nurse" means any person licensed as a professional nurse or as a licensed practical nurse by the Virginia Board of Nursing.

"Occupational outbreak" means a cluster of illness or disease that is indicative of a work-related exposure. Such conditions include but are not limited to silicosis, asbestosis, byssinosis, pneumoconiosis, and tuberculosis.

"Outbreak" means the occurrence of more cases of a disease than expected.

"Period of communicability" means the time or times during which the etiologic agent may be transferred directly or indirectly from an infected person to another person, or from an infected animal to a person.

"Physician" means any person licensed to practice medicine or osteopathy by the Virginia Board of Medicine.

"Quarantine" means the physical separation, including confinement or restriction of movement, of an individual or individuals who are present within an affected area or who are known to have been exposed, or may reasonably be suspected to have been exposed, to a communicable disease and who do not yet show signs or symptoms of infection with the communicable disease in order to prevent or limit the transmission of the communicable disease of public health threat to unexposed and uninfected individuals.

"Quarantine, complete" means the full-time confinement or restriction of movement of an individual or individuals who do not have signs or symptoms of infection but may have been exposed, or may reasonably be suspected to have been exposed, to a communicable disease of public health threat in order to prevent the transmission of the communicable disease of public health threat to uninfected individuals.

"Quarantine, modified" means a selective, partial limitation of freedom of movement or actions of an individual or individuals who do not have signs or symptoms of the infection but have been exposed to, or are reasonably suspected to have been exposed to, a communicable disease of public health threat. Modified quarantine may be designed to meet particular situations and includes but is not limited to limiting movement to the home, work, ~~and/or~~ or one or more other locations, the prohibition or restriction from using public or mass transportation, or requirements for the use of devices or procedures intended to limit disease transmission.

"Reportable disease" means an illness due to a specific toxic substance, occupational exposure, or infectious agent, which affects a susceptible individual, either directly, as from an

infected animal or person, or indirectly through an intermediate host, vector, or the environment, as determined by the board.

[~~"SARS" means severe acute respiratory syndrome (SARS)-associated coronavirus (SARS-CoV) disease, Middle East respiratory syndrome (MERS) associated coronavirus (MERS-CoV) disease, or another coronavirus causing a severe acute illness.~~]

"School" means (i) any public school from kindergarten through grade 12 operated under the authority of any locality within the Commonwealth, (ii) any private or [~~parochial~~ religious] school that offers instruction at any level or grade from kindergarten through grade 12; [and] (iii) any private or [~~parochial~~ religious] nursery school or preschool, or any private or [~~parochial~~ religious] child care center [required to be] licensed by the Commonwealth [; ~~and~~ (iv) any preschool ~~handicap classes or Head Start classes~~].

"Serology" means the testing of blood, serum, or other body fluids for the presence of antibodies or other markers of an infection or disease process.

"Surveillance" means the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice. A surveillance system includes the functional capacity for data analysis as well as the timely dissemination of these data to persons who can undertake effective prevention and control activities.

"Susceptible individual" means a person or animal who is vulnerable to or potentially able to contract a disease or condition. Factors that affect an individual's susceptibility include but are not limited to physical characteristics, genetics, previous or chronic exposures, chronic conditions or infections, immunization history, or use of medications.

"Toxic substance" means any substance, including any raw materials, intermediate products, catalysts, final products, or by-products of any manufacturing operation conducted in a commercial establishment, that has the capacity, through its physical, chemical or biological properties, to pose a substantial risk of death or impairment either immediately or over time, to the normal functions of humans, aquatic organisms, or any other animal but not including any pharmaceutical preparation which deliberately or inadvertently is consumed in such a way as to result in a drug overdose.

"Tubercle bacilli" means disease-causing organisms belonging to the Mycobacterium tuberculosis complex and includes Mycobacterium tuberculosis, Mycobacterium bovis, and Mycobacterium africanum or other members as may be established by the commissioner.

"Tuberculin skin test (TST)" means a test for demonstrating infection with tubercle bacilli, performed according to the Mantoux method, in which 0.1 ml of 5 TU strength tuberculin purified protein derivative (PPD) is injected intradermally on

the volar surface of the arm. Any reaction is observed 48-72 hours after placement and palpable induration is measured across the diameter transverse to the long axis of the arm. The measurement of the indurated area is recorded in millimeters and the significance of the measured induration is based on existing national and department guidelines.

"Tuberculosis" means a disease caused by tubercle bacilli.

"Tuberculosis, active disease" (also "active tuberculosis disease" and "active TB disease"), as defined by § 32.1-49.1 of the Code of Virginia, means a disease caused by an airborne microorganism and characterized by the presence of either (i) a specimen of sputum or other bodily fluid or tissue that has been found to contain tubercle bacilli as evidenced by culture or nucleic acid amplification, including preliminary identification by rapid methodologies; (ii) a specimen of sputum or other bodily fluid or tissue that is suspected to contain tubercle bacilli as evidenced by smear, and where sufficient clinical and radiographic evidence of active tuberculosis disease is present as determined by a physician licensed to practice medicine in Virginia; or (iii) sufficient clinical and radiographic evidence of active tuberculosis disease as determined by the commissioner is present, but a specimen of sputum or other bodily fluid or tissue containing, or suspected of containing, tubercle bacilli is unobtainable.

"Tuberculosis infection in children age less than 4 <4 years" means a significant reaction resulting from a tuberculin skin test (TST) or other approved test for latent infection without clinical or radiographic evidence of active tuberculosis disease, in children from birth up to their fourth birthday.

"Vaccinia, disease or adverse event" means vaccinia infection or serious or unexpected events in persons who received the smallpox vaccine or their contacts, including but not limited to bacterial infections, eczema vaccinatum, erythema multiforme, generalized vaccinia, progressive vaccinia, inadvertent inoculation, post-vaccinial encephalopathy or encephalomyelitis, ocular vaccinia, and fetal vaccinia.

"Waterborne outbreak" means two or more cases of a similar illness acquired through the ingestion of or other exposure to water contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to giardiasis, viral gastroenteritis, cryptosporidiosis, hepatitis A, cholera, and shigellosis. A single case of laboratory-confirmed primary amebic meningoencephalitis or of waterborne chemical poisoning is considered an outbreak.

12VAC5-90-50. Applicability. (Repealed.)

~~A. This chapter has general application throughout the Commonwealth.~~

~~B. The provisions of the Virginia Administrative Process Act, which is codified as Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia shall govern the adoption, amendment, modification, and revision of this chapter, and the conduct of all proceedings and appeals hereunder. All~~

~~hearings on such regulations shall be conducted in accordance with § 2.2-4007.01 of the Code of Virginia.~~

Part III
Reporting of Disease

12VAC5-90-80. Reportable disease list Lists of diseases that shall be reported.

A. Reportable disease list. The board declares suspected or confirmed cases of the following named diseases, toxic effects, and conditions to be reportable by the persons enumerated in 12VAC5-90-90. Conditions identified by an asterisk (*) require immediate communication to the local health department by the most rapid means available upon suspicion or confirmation, as defined in subsection C of this section. Other conditions should be reported within three days of suspected or confirmed diagnosis.

- Acquired immunodeficiency syndrome (AIDS)
- Amebiasis
- *Anthrax
- Arboviral infections (e.g., [CHIK,] dengue, EEE, LAC, SLE, ~~WNV~~) [WNV, Zika]
- Babesiosis
- *Botulism
- *Brucellosis
- Campylobacteriosis
- Chancroid
- Chickenpox (Varicella)
- Chlamydia trachomatis infection
- *Cholera
- [*Coronavirus infection, severe]
- Creutzfeldt-Jakob disease if <55 years of age
- Cryptosporidiosis
- Cyclosporiasis
- *Diphtheria
- *Disease caused by an agent that may have been used as a weapon
- Ehrlichiosis/Anaplasmosis
- Escherichia coli infection, Shiga toxin-producing
- Giardiasis
- Gonorrhea
- Granuloma inguinale
- *Haemophilus influenzae infection, invasive
- Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome (HUS)
- *Hepatitis A
- Hepatitis B (acute and chronic)
- Hepatitis C (acute and chronic)
- Hepatitis, other acute viral

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Human immunodeficiency virus (HIV) infection
Influenza
*Influenza-associated deaths in children <18 years of age
Lead, [~~elevated blood~~ reportable] levels
Legionellosis
Leprosy (~~Hansen~~ (Hansen's disease))
Leptospirosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
*Measles (Rubeola)
*Meningococcal disease
~~*Monkeypox~~
Mumps
Ophthalmia neonatorum
*Outbreaks, all (including but not limited to foodborne, [healthcare-associated ~~health~~ care-associated], occupational, toxic substance-related, and waterborne)
*Pertussis
*Plague
*Poliovirus infection, including poliomyelitis
*Psittacosis
*Q fever
*Rabies, human and animal
Rabies treatment, post-exposure
*Rubella, including congenital rubella syndrome
Salmonellosis
[~~*Severe acute respiratory syndrome (SARS), including any coronavirus causing a severe acute illness~~]
Shigellosis
*Smallpox (Variola)
Spotted fever rickettsiosis
Staphylococcus aureus infection, vancomycin-intermediate or vancomycin-resistant
Streptococcal disease, Group A, invasive or toxic shock
Streptococcus pneumoniae infection, invasive, in children <5 years of age
Syphilis (report *primary and *secondary syphilis by rapid means)
Tetanus
Toxic substance-related illness
Trichinosis (Trichinellosis)
*Tuberculosis, active disease
Tuberculosis infection in children <4 years of age

*Tularemia
*Typhoid/Paratyphoid fever
*Unusual occurrence of disease of public health concern
*Vaccinia, disease or adverse event
*Vibrio infection
*Viral hemorrhagic fever
*Yellow fever
Yersiniosis

B. Conditions reportable by directors of laboratories.

Conditions identified by an asterisk (*) require immediate communication to the local health department by the most rapid means available upon suspicion or confirmation, as defined in subsection C of this section. Other conditions should be reported within three days of suspected or confirmed diagnosis.

Amebiasis - by microscopic examination, culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

*Anthrax - by culture, antigen detection [~~or~~], nucleic acid detection [, or serologic results consistent with recent infection]

Arboviral infection [e.g., CHIK, dengue, EEE, LAC (also known as California encephalitis), SLE, WNV, Zika] - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

Babesiosis - by culture, antigen detection, nucleic acid detection, [microscopic examination,] or serologic results consistent with recent infection

*Botulism - by culture, nucleic acid detection, or identification of ~~toxin~~ neurotoxin in a clinical specimen

*Brucellosis - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

Campylobacteriosis - by culture [or culture-independent diagnostic test (CIDT) (i.e., antigen detection [~~or~~] or nucleic acid detection [])]. [For CIDT, also] submit all [available] culture results (positive or negative) associated with a positive [antigen detection test result].

Chancroid - by culture, antigen detection, or nucleic acid detection

Chickenpox (~~varicella~~) (Varicella) - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

Chlamydia trachomatis infection - by culture, antigen detection, nucleic acid detection or, for lymphogranuloma venereum, serologic results consistent with recent infection

*Cholera - by culture [, antigen detection, nucleic acid detection,] or serologic results consistent with recent infection

[*Coronavirus infection, severe - by culture, nucleic acid detection, or serologic results consistent with recent infection]

Creutzfeldt-Jakob disease if <55 years of age by histopathology in patients under the age of 55 years

Cryptosporidiosis - by microscopic examination, antigen detection, or nucleic acid detection

Cyclosporiasis - by microscopic examination or nucleic acid detection

*Diphtheria - by culture or histopathology

Ehrlichiosis/Anaplasmosis - by culture, nucleic acid detection, [microscopic examination,] or serologic results consistent with recent infection

Escherichia coli infection, Shiga toxin-producing - by culture of E. coli O157 or other Shiga toxin producing E. coli, Shiga toxin detection (e.g., [by nucleic acid detection,] EIA), or [nucleic acid detection serologic results consistent with recent infection]

Giardiasis - by microscopic examination ~~or~~, antigen detection, or nucleic acid detection

Gonorrhea - by microscopic examination of a urethral smear [~~specimen~~] (males only) [or endocervical smear (females only)], culture, antigen detection, or nucleic acid detection. Include available antimicrobial susceptibility findings in report.

*Haemophilus influenzae infection, invasive - by culture, antigen detection, or nucleic acid detection from a normally sterile site

Hantavirus pulmonary syndrome - by antigen detection (immunohistochemistry), nucleic acid detection, or serologic results consistent with recent infection

*Hepatitis A - by detection of IgM antibodies

Hepatitis B (acute and chronic) - by detection of HBsAg, HBeAg, or IgM antibodies or nucleic acid detection. For any reportable hepatitis finding, submit all available results from the hepatitis panel. [Submit all findings for hepatitis B testing in children younger than two years of age.]

Hepatitis C (acute and chronic) - by hepatitis C virus antibody (anti-HCV) [~~screening test~~] positive [~~with a signal to cutoff ratio predictive of a true positive as determined for the particular assay as defined by CDC, HCV antibody positive by immunoblot (RIBA)~~], [HCV antigen positive,] or HCV RNA positive by nucleic acid test. For all hepatitis C patients, also report available results of serum alanine aminotransferase (ALT) [~~anti-HAV IgM, anti HBe IgM, and HBsAg~~. For any reportable hepatitis finding, submit and] all available results from the hepatitis panel.

Hepatitis, other acute viral – any finding indicative of acute infection with hepatitis D, E, or other cause of viral hepatitis. For any reportable hepatitis finding, submit all available results from the hepatitis panel.

Human immunodeficiency virus (HIV) infection - by culture, antigen detection, nucleic acid detection, or detection of antibody ~~confirmed with a supplemental test~~. For HIV-infected patients, report all results of CD4 and HIV viral load tests [~~and, including undetectable viral loads~~. For HIV-infected patients, report] all HIV genetic [nucleotide] sequence data associated with HIV drug resistance tests [by electronic submission]. For children [from birth to less than] three years of age, report all tests regardless of the test findings (e.g., negative or positive).

Influenza - by culture, antigen detection by direct fluorescent antibody (DFA), or nucleic acid detection

Lead, [~~elevated blood reportable~~] levels - [by blood lead level greater than or equal to 10 µg/dL in children ages 0–15 years, or greater than or equal to 25 µg/dL in persons older than 15 years of age [the reference value established by CDC. The reference value established in 2012 was 5 µg/dL in children and 10 by any detectable blood lead level in children ages 0-15 years or levels greater than or equal to 5] µg/dL in persons older than 15 years of age [;]

Legionellosis - by culture, antigen detection (including urinary antigen), nucleic acid detection, or serologic results consistent with recent infection

Leptospirosis - by culture, microscopic examination by dark field microscopy, nucleic acid detection, or serologic results consistent with recent infection

Listeriosis - by culture [from a normally sterile site. If associated with miscarriage or stillbirth, by culture from placental or fetal tissue]

Lyme disease - by culture, antigen detection, or detection of antibody confirmed with a supplemental test

Malaria - by microscopic examination, antigen detection, or nucleic acid detection

*Measles (~~rubeola~~) (Rubeola) - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

*Meningococcal disease - by culture [nucleic acid detection,] or antigen detection from a normally sterile site

~~*Monkeypox – by culture or nucleic acid detection~~

Mumps - by culture, nucleic acid detection, or serologic results consistent with recent infection

*Mycobacterial diseases - (See 12VAC5-90-225 B) Report any of the following:

1. Acid fast bacilli by microscopic examination;
2. Mycobacterial identification - preliminary and final identification by culture or nucleic acid detection;
3. Drug susceptibility test results for M. tuberculosis.

*Pertussis - by culture, antigen detection, [~~or~~] nucleic acid detection [, or serologic results consistent with recent infection]

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*Plague - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

*Poliovirus infection - by culture

*Psittacosis - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

*Q fever - by culture, antigen detection, nucleic acid detection, [immunohistochemical methods,] or serologic results consistent with recent infection

*Rabies, human and animal - by culture, antigen detection by direct fluorescent antibody test, nucleic acid detection, or, for humans only, serologic results consistent with recent infection

*Rubella - by culture, nucleic acid detection, or serologic results consistent with recent infection

Salmonellosis - by culture [~~or~~,] antigen detection [, or nucleic acid detection]

[~~*Severe acute respiratory syndrome, including any coronavirus causing a severe acute illness~~ by culture, nucleic acid detection, or serologic results consistent with recent infection]

Shigellosis - by culture [~~or~~,] antigen detection [, or nucleic acid detection]

*Smallpox (~~variola~~) (Variola) - by culture or nucleic acid detection

Spotted fever rickettsiosis - by culture, antigen detection (including immunohistochemical staining), nucleic acid detection, or serologic results consistent with recent infection

Staphylococcus aureus infection, resistant, as defined below:

1. ~~Methicillin resistant by antimicrobial susceptibility testing of a Staphylococcus aureus isolate, with a susceptibility result indicating methicillin resistance, cultured from a normally sterile site~~

2. Vancomycin-intermediate or vancomycin-resistant Staphylococcus aureus infection - by antimicrobial susceptibility testing of a Staphylococcus aureus isolate, with a vancomycin susceptibility result of intermediate or resistant, cultured from a clinical specimen. Include available antimicrobial susceptibility findings in report.

Streptococcal disease, Group A, invasive or toxic shock - [for invasive disease,] by culture from a normally sterile site [: for streptococcal toxic shock, by culture from any body site]

Streptococcus pneumoniae infection, invasive, in children <5 years of age - by culture from a normally sterile site in a child under the age of five years

*Syphilis - by [~~microscopic examination (including dark field)~~ darkfield microscopy,] antigen detection,

[~~(including direct fluorescent antibody)~~ nucleic acid detection,] or serology by either treponemal or nontreponemal methods

Toxic substance-related illness - by blood or urine laboratory findings above the normal range, including but not limited to heavy metals, pesticides, and industrial-type solvents and gases. When applicable and available, report speciation of metals when blood or urine levels are elevated in order to differentiate the chemical species (elemental, organic, or inorganic).

Trichinosis (~~trichinellosis~~) (Trichinellosis) - by microscopic examination of a muscle biopsy or serologic results consistent with recent infection

*Tularemia - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

*Typhoid/Paratyphoid fever - by culture [, antigen detection, or nucleic acid detection]

*Vaccinia, disease or adverse event - by culture or nucleic acid detection

*Vibrio infection - [~~by culture. Include Photobacterium damsela and Grimontia hollisae as well as Vibrio species.~~ isolation of any species of the family Vibrionaceae (other than toxigenic Vibrio cholera O1 or O139, which are reportable as cholera) from a clinical specimen by culture, antigen detection, or nucleic acid detection]

*Viral hemorrhagic fever - by culture, antigen detection (including immunohistochemical staining), nucleic acid detection, or serologic results consistent with recent infection

*Yellow fever - by culture, antigen detection, nucleic acid detection, or serologic results consistent with recent infection

Yersiniosis - by culture, nucleic acid detection, or serologic results consistent with recent infection

C. Reportable diseases requiring rapid communication. Certain of the diseases in the list of reportable diseases, because of their extremely contagious nature or their potential for greater harm, or both, require immediate identification and control. Reporting of persons confirmed or suspected of having these diseases, listed below, shall be made immediately by the most rapid means available, preferably ~~that of telecommunication (e.g., by telephone, telephone transmitted facsimile, pagers, etc.)~~ to the local health director ~~or other professional employee of the~~ department. (These same diseases are also identified by an asterisk (*) in ~~subsection A and subsection B~~ subsections A and B, where applicable, of this section.)

Anthrax

Botulism

Brucellosis

Cholera

[Coronavirus infection, severe]

- Diphtheria
- Disease caused by an agent that may have been used as a weapon
- Haemophilus influenzae infection, invasive
- Hepatitis A
- Influenza-associated deaths in children <18 years of age
- Influenza A, novel virus
- Measles (Rubeola)
- Meningococcal disease
- ~~Monkeypox~~
- Outbreaks, all
- Pertussis
- Plague
- Poliovirus infection, including poliomyelitis
- Psittacosis
- Q fever
- Rabies, human and animal
- Rubella, including congenital rubella syndrome
- [~~Severe acute respiratory syndrome (SARS), including any coronavirus causing a severe acute illness~~]
- Smallpox (Variola)
- Syphilis, primary and secondary
- Tuberculosis, active disease
- Tularemia
- ~~*Typhoid/Paratyphoid~~ Typhoid/Paratyphoid fever
- Unusual occurrence of disease of public health concern
- Vaccinia, disease or adverse event
- Vibrio infection
- Viral hemorrhagic fever
- Yellow fever

D. Toxic substance-related illnesses. All toxic substance-related illnesses, including pesticide and heavy metal poisoning or illness resulting from exposure to an occupational dust or fiber or radioactive substance, shall be reported.

If such illness is verified or suspected and presents an emergency or a serious threat to public health or safety, the report of such illness shall be ~~by rapid communication as in subsection C of this section~~ made immediately by the most rapid means available [, preferably by telephone].

E. Outbreaks. The occurrence of outbreaks or clusters of any illness which may represent a group expression of an illness which may be of public health concern shall be reported to the local health department immediately by the most rapid means available [, preferably by telephone].

F. Unusual or ill-defined diseases or emerging or reemerging pathogens. Unusual or emerging conditions of public health concern shall be reported to the local health department immediately by the most rapid means available [, preferably by telephone]. In addition, the commissioner or his designee may establish surveillance systems for diseases or conditions that are not on the list of reportable diseases. Such surveillance may be established to identify cases (delineate the magnitude of the situation), to identify the mode of transmission and risk factors for the disease, and to identify and implement appropriate action to protect public health. Any person reporting information at the request of the department for special surveillance or other epidemiological studies shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

12VAC5-90-90. Those required to report.

A. Physicians. Each physician who treats or examines any person who is suffering from or who is suspected of having a reportable disease or condition shall report that person's name, address, age, date of birth, race, sex, and pregnancy status for females; name of disease diagnosed or suspected; the date of onset of illness; [available laboratory tests and results;] and the name, address, and telephone number of the physician and medical facility where the examination was made, except that influenza should be reported by number of cases only (and type of influenza, if available). Reports are to be made to the local health department serving the jurisdiction where the physician practices. A physician may designate someone to report on his behalf, but the physician remains responsible for ensuring that the appropriate report is made. Any physician, designee, or organization making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

Such reports shall be made on a ~~form to be provided by the department (Form Epi-1)~~ Form Epi-1, a computer generated printout containing the data items requested on Form Epi-1, or a ~~Centers for Disease Control and Prevention (CDC) CDC [or VDH]~~ surveillance form that provides the same information and shall be made within three days of the suspicion or confirmation of disease unless the disease in question requires rapid reporting under 12VAC5-90-80 C except that those identified in 12VAC5-90-80 C shall be reported immediately by the most rapid means available [, preferably by telephone,] to the local health department serving the jurisdiction in which the facility is located. Reporting may be done by means of secure electronic transmission upon agreement of the physician and the department.

~~Pursuant to § 32.1-49.1 of the Code of Virginia, additional~~ Additional elements are required to be reported for individuals with confirmed or suspected active tuberculosis disease. Refer to Part X (12VAC5-90-225 et seq.) for details on these requirements.

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B. Directors of laboratories. ~~[Any person] who is [in charge of a laboratory conducting business in the Commonwealth Laboratory directors]~~ shall report any laboratory examination of any clinical specimen, whether performed in-house or referred to an out-of-state laboratory, which yields evidence, by the laboratory method(s) indicated or any other confirmatory test, of a disease listed in 12VAC5-90-80 B.

Each report shall give the source of the specimen and the laboratory method and result; the name, address, age, date of birth, race, sex, and pregnancy status for females (if known) of the person from whom the specimen was obtained; and the name, address, and telephone number of the physician ~~[for whom at whose request]~~ and medical facility ~~for whom at which~~ the examination was made. When the influenza virus is isolated, the type should be reported, if available. Reports shall be made within three days of identification of evidence of disease, except that those identified ~~by an asterisk in 12VAC5-90-80 C~~ shall be reported immediately by the most rapid means available, ~~[, preferably by telephone,]~~ to the local health department serving the jurisdiction in which the laboratory is located. Reports shall be made on Form Epi-1 or on the laboratory's own form if it includes the required information. Computer generated reports containing the required information may be submitted. Reporting may be done by means of secure electronic transmission upon agreement of the laboratory director and the department. [Reports of HIV genetic nucleotide sequence data associated with HIV drug resistance tests must be submitted electronically.] Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

A laboratory identifying evidence of any of the following conditions shall notify the local health department of the positive culture or other positive test result within the timeframes specified in 12VAC5-90-80 and submit the initial isolate or other initial specimen to the Virginia Division of Consolidated Laboratory Services (~~DCLS~~) within seven days of identification. All specimens must be identified with the patient and physician information required in this subsection.

Anthrax

[Botulism]

Brucellosis

Cholera

Diphtheria

E. coli infection, Shiga toxin-producing. (Laboratories that use a Shiga toxin EIA methodology but do not perform simultaneous culture for Shiga toxin-producing E. coli should forward all positive stool specimens or positive ~~broth cultures~~ enrichment broths to ~~DCLS~~ the Division of Consolidated Laboratory Services for confirmation and further characterization.)

Haemophilus influenzae infection, invasive

~~[Human immunodeficiency virus (HIV) (Submit all remnant HIV diagnostic sera to the Division of Consolidated Laboratory Services or other laboratory designated by the department for HIV recency testing.)]~~

Influenza A, novel virus

Listeriosis

Meningococcal disease

Pertussis

Plague

Poliovirus infection

Q fever

Salmonellosis

Shigellosis

Streptococcal disease, Group A, invasive

Tuberculosis (A laboratory identifying Mycobacterium tuberculosis complex (see 12VAC5-90-225) shall submit a representative and viable sample of the initial culture to ~~DCLS~~ the Division of Consolidated Laboratory Services or other laboratory designated by the board to receive such specimen.)

[Tularemia]

Typhoid/Paratyphoid fever

Vancomycin-intermediate or vancomycin-resistant Staphylococcus aureus infection

Vibrio infection, including infections due to Photobacterium damsela and Grimontia hollisae

Yersiniosis

Other diseases as may be requested by the health department

When a clinical specimen yields evidence indicating the presence of a select agent or toxin as defined by federal regulations in 42 CFR Part 73, the person in charge of the laboratory shall contact the Division of Consolidated Laboratory Services and arrange to forward an isolate for confirmation. If a select agent or toxin has been confirmed in a clinical specimen, the laboratory director shall consult with Division of Consolidated Laboratory Services or CDC regarding isolate transport or destruction.

Laboratories operating within a medical care facility shall be considered to be in compliance with the requirement to notify the local health department when the director of that medical care facility assumes the reporting responsibility; however, laboratories are still required to submit isolates to ~~DCLS~~ the Division of Consolidated Laboratory Services or other designated laboratory as noted ~~above~~ in this subsection.

C. Persons in charge of a medical care facility. Any person in charge of a medical care facility shall make a report to the local health department serving the jurisdiction where the facility is located of the occurrence in or admission to the facility of a patient with a reportable disease listed in

12VAC5-90-80 A unless he has evidence that the occurrence has been reported by a physician. Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia. The requirement to report shall include all inpatient, outpatient, and emergency care departments within the medical care facility. Such report shall contain the patient's name, address, age, date of birth, race, sex, and pregnancy status for females; name of disease being reported; [available laboratory tests and results;] the date of admission; hospital chart number; date expired (when applicable); and attending physician. Influenza should be reported by number of cases only (and type of influenza, if available). Reports shall be made within three days of the suspicion or confirmation of disease ~~unless the disease in question requires rapid reporting under 12VAC5-90-80 C and except that those identified in 12VAC5-90-80 C shall be reported immediately by the most rapid means available [, preferably by telephone,] to the local health department serving the jurisdiction in which the facility is located. Reports~~ shall be made on Form Epi-1, a computer generated printout containing the data items requested on Form Epi-1, or a ~~Centers for Disease Control and Prevention (CDC) CDC [or VDH]~~ surveillance form that provides the same information. Reporting may be done by means of secure electronic transmission upon agreement of the medical care facility and the department.

A person in charge of a medical care facility may assume the reporting responsibility on behalf of the director of the laboratory operating within the facility.

D. Persons in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, child care center, or summer camp. Any person in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, child care center, or summer camp as defined in § 35.1-1 of the Code of Virginia shall report immediately to the local health department the presence or suspected presence in his program, service, facility, school, child care center, or summer camp of persons who have common symptoms suggesting an outbreak situation. Such persons may report additional information, including ~~individual cases of~~ identifying and contact information for individuals with communicable diseases of public health concern or individuals who are involved in outbreaks that occur in their facilities, as necessary to facilitate public health investigation and disease control. Any person so reporting shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

E. Local health directors. The local health director shall forward any report of a disease or report of evidence of a disease which has been made on a resident of his jurisdiction to the Office of Epidemiology within three days of receipt. This report shall be submitted immediately by the most rapid means available if the disease is one requiring rapid communication, as required in 12VAC5-90-80 C. All such

rapid reporting shall be confirmed in writing and submitted to the Office of Epidemiology, by either a paper report or entry into a shared secure electronic disease surveillance system, within three days. Furthermore, the local health director shall immediately forward to the appropriate local health director any disease reports on individuals residing in the latter's jurisdiction or to the Office of Epidemiology on individuals residing outside Virginia. The Office of Epidemiology shall be responsible for notifying other state health departments of reported illnesses in their residents and [~~of for~~] notifying CDC as necessary and appropriate.

F. Persons in charge of hospitals, nursing facilities or nursing homes, assisted living facilities, and correctional facilities. In accordance with § 32.1-37.1 of the Code of Virginia, any person in charge of a hospital, nursing facility or nursing home, assisted living facility, or correctional facility shall, at the time of transferring custody of any dead body to any person practicing funeral services, notify the person practicing funeral services or his agent if the dead person was known to have had, immediately prior to death, an infectious disease which may be transmitted through exposure to any bodily fluids. These include any of the following infectious diseases:

- Creutzfeldt-Jakob disease
- Human immunodeficiency virus infection
- Hepatitis B
- Hepatitis C
- ~~Monkeypox~~
- Rabies
- Smallpox
- Syphilis, infectious
- Tuberculosis, active disease
- Vaccinia, disease or adverse event
- Viral hemorrhagic fever

G. Employees, [applicants, conditional employees,] and persons in charge of food establishments. 12VAC5-421-80 of the Food Regulations requires a food employee or ~~applicant~~ conditional employee to notify the person in charge of the food establishment when diagnosed with certain diseases that are transmissible through food. ~~12VAC5-421-120 and~~ requires the person in charge of the food establishment to notify the ~~health department regulatory authority.~~ Refer to the ~~appropriate sections of the Virginia Administrative Code 12VAC5-421-80~~ for further guidance and clarification regarding these reporting requirements.

Part IV
Control of Disease

12VAC5-90-100. Methods.

The board and commissioner shall use appropriate disease control measures to manage the diseases listed in 12VAC5-90-80 A, including but not limited to those described in the

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"Methods of Control" sections of the ~~18th~~ 20th Edition of the Control of Communicable Diseases Manual (~~2004~~) (2015) published by the American Public Health Association. The board and commissioner reserve the right to use any legal means to control any disease which is a threat to the public health.

When notified about a disease specified in 12VAC5-90-80, the local health director or his designee shall have the authority and responsibility to perform contact tracing/contact services for HIV infection, infectious syphilis, and active tuberculosis disease and may perform contact services for the other diseases if deemed necessary to protect the public health. All contacts of HIV infection shall be afforded the opportunity for appropriate counseling, testing, and individual face-to-face disclosure of their test results. In no case shall names of informants or infected individuals be revealed to contacts by the health department. All information obtained shall be kept strictly confidential.

The local health director or his designee shall review reports of diseases received from his jurisdiction and follow up such reports, when indicated, with an appropriate investigation in order to evaluate the severity of the problem. The local health director or his designee may recommend to any individual or group of individuals appropriate public health control measures, including but not limited to quarantine, isolation, immunization, decontamination, or treatment. He shall determine in consultation with the Office of Epidemiology and the commissioner if further investigation is required and if one or more forms of quarantine ~~and/or~~, isolation, or both will be necessary.

Complete isolation shall apply to situations where an individual is infected with a communicable disease of public health significance (including but not limited to active tuberculosis disease or HIV infection) and is engaging in behavior that places others at risk for infection with the communicable disease of public health significance, in accordance with the provisions of Article 3.01 (§ ~~32.1-48.02~~ 32.1-48.01 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia.

Modified isolation shall apply to situations in which the local health director determines that modifications of activity are necessary to prevent disease transmission. Such situations shall include but are not limited to the temporary exclusion of a child with a communicable disease from school, the temporary exclusion of an individual with a communicable disease from food handling or patient care, the temporary prohibition or restriction of an individual with a communicable disease from using public transportation, the requirement that a person with a communicable disease use certain personal protective equipment, or restrictions of other activities that may pose a risk to the health of others.

Protective isolation shall apply to situations such as the exclusion, under § 32.1-47 of the Code of Virginia, of any unimmunized child from a school in which an outbreak,

potential epidemic, or epidemic of a vaccine preventable disease has been identified.

To the extent permitted by the Code of Virginia, the local health director may be authorized as the commissioner's designee to implement the forms of isolation described in this section. When these forms of isolation are deemed to be insufficient, the local health director may use the provisions of Article 3.01 (§ 32.1-48.01 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia for the control of communicable diseases of public health significance or, in consultation with the Office of Epidemiology, shall provide sufficient information to enable the commissioner to prepare an order or orders of isolation ~~and/or~~, quarantine, or both under Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia for the control of communicable diseases of public health threat.

Part V

Immunization of Persons Less Than 18 Years of Age

12VAC5-90-110. Dosage and age requirements for immunizations; obtaining immunizations.

A. Every person in Virginia less than 18 years of age shall be immunized in accordance with the most recent Immunization Schedule developed and published by the ~~Centers for Disease Control and Prevention (CDC)~~ CDC, Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Requirements for school and day care attendance are addressed in 12VAC5-110.

B. The required immunizations may be obtained from a physician ~~licensed to practice medicine or from the local health department~~, registered nurse, or other licensed professional [as] authorized by the Code of Virginia [to administer immunizations at locations to include private settings or local health departments].

Part XIII

Reporting of Dangerous Microbes and Pathogens

12VAC5-90-280. Definitions. Reporting of dangerous microbes and pathogens.

A. Definitions. The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise:

"Biologic agent" means any microorganism (including, but not limited to, bacteria, viruses, fungi, rickettsiae, or protozoa), or infectious substance, or any naturally occurring, bioengineered, or synthesized component of any such microorganism or infectious substance, capable of causing death, disease, or other biological malfunction in a human, an animal, a plant, or other living organism; deterioration of food, water, equipment, supplies, or material of any kind; or deleterious alteration of the environment.

"CDC" means the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.

"Diagnosis" means the analysis of specimens for the purpose of identifying or confirming the presence or characteristics of a select agent or toxin, provided that such analysis is directly related to protecting the public health or safety.

"Proficiency testing" means a sponsored, time-limited analytical trial whereby one or more analytes, previously confirmed by the sponsor, are submitted to the testing laboratory for analysis and where final results are graded, scores are recorded and provided to participants, and scores for participants are evaluated.

"Responsible official" means any person in charge of directing or supervising a laboratory conducting business in the Commonwealth of Virginia. At colleges and universities, the responsible official shall be the president of the college or university or his designee. At private, state, or federal organizations, the responsible official shall be the laboratory director or a chief officer of the organization or his designee.

"Select agent or toxin" or "select agent and toxin" means all those biological agents or toxins as defined by federal regulations in 42 CFR Part 73, including: ~~1. Health and Human Services (HHS) select agents and toxins, as outlined in 42 CFR 73.4 and overlap select agents and toxins.~~

~~2. HHS overlap select agents and toxins, as outlined in 42 CFR 73.5.~~

"Toxin" means the toxic material or product of plants, animals, microorganisms (including but not limited to bacteria, viruses, fungi, rickettsiae, or protozoa); or infectious substances; or a recombinant or synthesized molecule, whatever the origin and method of production; and includes any poisonous substance or biological product that may be engineered as a result of biotechnology or produced by a living organism; or any poisonous isomer or biological product, homolog, or derivative of such a substance.

"Verification" means the process required to assure the accuracy, precision, and the analytical sensitivity and specificity of any procedure used for diagnosis.

B. Administration. The dangerous microbes and pathogens will be known as "select agents and toxins." The select agent and toxin registry will be maintained by the Virginia Department of Health, Office of Epidemiology, Division of Surveillance and Investigation.

C. Reportable agents. The board declares the select agents and toxins and overlap select agents and toxins outlined in 42 CFR Part 73 to be reportable and adopts it herein by reference including subsequent amendments and editions. The select agents and toxins are to be reportable by the persons enumerated in subsection F of this section.

D. Items to report. Each report shall be made on a form determined by the department and shall contain the following: name, source and characterization information on select

agents and toxins and quantities held; objectives of the work with the agent; location (including building and room) where each select agent or toxin is stored or used; identification information of persons with access to each agent; identification information of the person in charge of each of the agents; and the name, position and identification information of one responsible official as a single point of contact for the organization. The report shall also indicate whether the laboratory is registered with the CDC Select Agent Program and may contain additional information as required by 42 CFR Part 73 or the department.

E. Timing of reports. Reports shall be made to the department within seven calendar days of submission of an application to the CDC Select Agent Program. By January 31 of every year, laboratories shall provide a written update to the department, which shall include a copy of the federal registration certificate received through the CDC Select Agent Program.

In the event that a select agent or toxin that has previously been reported to the department is destroyed, a copy of federal forms addressing the destruction of the select agent or toxin must be submitted to the department within seven calendar days of submission to the CDC Select Agent Program.

In the event that a select agent or toxin, or a specimen or isolate from a specimen containing a select agent or toxin, has previously been reported to the department and is subsequently transferred to a facility eligible for receiving the items, a copy of federal forms addressing the transfer of the select agent or toxin must be submitted to the department within seven calendar days of submission to the CDC Select Agent Program.

In the event of a suspected release, loss, or theft of any select agent or toxin, the responsible official at a laboratory shall make a report to the department immediately by the most rapid means available, preferably by telephone. The rapid report shall be followed up by a written report within seven calendar days and shall include the following information:

1. The name of the biologic agent and any identifying information (e.g., strain or other characterization information);
2. An estimate of the quantity released, lost, or stolen;
3. An estimate of the time during which the release, loss, or theft occurred; and
4. The location (building, room) from or in which the release, loss, or theft occurred. The report may contain additional information as required by 42 CFR Part 73 or the department.

The department [~~must~~ shall] be notified in writing of any change to information previously submitted to the department. If a new application or an amendment to an existing application is filed with the CDC Select Agent

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Program, a copy of the application or amendment [~~must shall~~] be submitted to the department within seven calendar days of submission to the CDC Select Agent Program.

~~F. Those required to report. The [responsible official in charge of a laboratory conducting business in the Commonwealth laboratory director] shall be responsible for annual reporting of select agents and toxins to the Virginia Department of Health and for the reporting of any changes within the time periods as specified within these regulations. Such reports shall be made on forms to be determined by the department. Any person making such reports as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.~~

~~G. Exemption from reporting. A person who detects a select agent or toxin for the purpose of diagnosing a disease, verification, or proficiency testing and either transfers the specimens or isolates containing the select agent or toxin to a facility eligible for receiving them or destroys them on site is not required to make a report except as required by 12VAC5-90-80 and 12VAC5-90-90. Proper destruction of the agent [must shall] take place through autoclaving, incineration, or by a sterilization or neutralization process sufficient to cause inactivation. The transfer or destruction [must shall] occur within seven calendar days after identification of a select agent or toxin used for diagnosis or testing and within 90 calendar days after receipt for proficiency testing.~~

~~Any additional exemptions from reporting under 42 CFR Part 73, including subsequent amendments and editions, are also exempt from reporting under this regulation; however, the department [must shall] be notified of the exemption by submitting a copy of federal forms addressing the exemption within seven calendar days of submission to the CDC Select Agent Program.~~

~~H. Release of reported information. Reports submitted to the select agent and toxin registry shall be confidential and shall not be a public record pursuant to the Freedom of Information Act, regardless of submitter. Release of information on select agents or toxins shall be made only by order of the State Health Commissioner to the CDC and state and federal law-enforcement agencies in any investigation involving the release, theft, or loss of a select agent or toxin required to be reported to the department under this regulation.~~

12VAC5-90-290. Authority. (Repealed.)

~~Chapter 2 (§ 32.1-35 et seq.) of Title 32.1 of the Code of Virginia authorizes the reporting of dangerous microbes and pathogens to the department. Specifically, § 32.1-35 directs the board to promulgate regulations specifying which dangerous microbes and pathogens are to be reportable and the method and timeframe by which they are to be reported by laboratories.~~

12VAC5-90-300. Administration. (Repealed.)

~~The dangerous microbes and pathogens will be known as "select agents and toxins." The select agent and toxin registry~~

~~will be maintained by the Virginia Department of Health, Office of Epidemiology, Division of Surveillance and Investigation.~~

12VAC5-90-310. Reportable agents. (Repealed.)

~~The board declares the select agents and toxins outlined in 42 CFR 73.4 and 42 CFR 73.5 to be reportable, and adopts it herein by reference including subsequent amendments and editions. The select agents and toxins are to be reportable by the persons enumerated in 12VAC5-90-340.~~

12VAC5-90-320. Items to report. (Repealed.)

~~Each report shall be made on a form determined by the department and shall contain the following: name, source and characterization information on select agents and toxins and quantities held; objectives of the work with the agent; location (including building and room) where each select agent or toxin is stored or used; identification information of persons with access to each agent; identification information of the person in charge of each of the agents; and the name, position and identification information of one responsible official as a single point of contact for the organization. The report shall also indicate whether the laboratory is registered with the CDC Select Agent Program and may contain additional information as required by 42 CFR Part 73 or the department.~~

12VAC5-90-330. Timing of reports. (Repealed.)

~~Initial reports shall be made by October 26, 2004. Thereafter, reports shall be made to the department within seven calendar days of submission of an application to the CDC Select Agent Program. By January 31 of every year, laboratories shall provide a written update to the department, which shall include a copy of the federal registration certificate received through the CDC Select Agent Program.~~

~~In the event that a select agent or toxin that has previously been reported to the department is destroyed, a copy of federal forms addressing the destruction of the select agent or toxin must be submitted to the department within seven calendar days of submission to the CDC Select Agent Program.~~

~~In the event that a select agent or toxin, or a specimen or isolate from a specimen containing a select agent or toxin, has previously been reported to the department and is subsequently transferred to a facility eligible for receiving the items, a copy of federal forms addressing the transfer of the select agent or toxin must be submitted to the department within seven calendar days of submission to the CDC Select Agent Program.~~

~~In the event of a suspected release, loss or theft of any select agent or toxin, the responsible official at a laboratory shall make a report to the department within 24 hours by the most rapid means available, preferably that of telecommunication (e.g., telephone, telephone transmitted facsimile, pagers, etc.) The rapid report shall be followed up by a written report~~

within seven calendar days and shall include the following information:

1. The name of the biologic agent and any identifying information (e.g., strain or other characterization information);
2. An estimate of the quantity released, lost or stolen;
3. An estimate of the time during which the release, loss or theft occurred; and
4. The location (building, room) from or in which the release, loss or theft occurred. The report may contain additional information as required by 42 CFR Part 73 or the department.

The department must be notified in writing of any changes to information previously submitted to the department. If a new application or an amendment to an existing application is filed with the CDC Select Agent Program, a copy of the application or amendment must be submitted to the department within seven calendar days of submission to the CDC Select Agent Program.

12VAC5-90-340. Those required to report. (Repealed.)

The responsible official in charge of a laboratory conducting business in the Commonwealth shall be responsible for annual reporting of select agents and toxins to the Virginia Department of Health and for the reporting of any changes within the time periods as specified within these regulations. Such reports shall be made on forms to be determined by the department. Any person making such reports as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

12VAC5-90-350. Exemption from reporting. (Repealed.)

A person who detects a select agent or toxin for the purpose of diagnosing a disease, verification, or proficiency testing and either transfers the specimens or isolates containing the select agent or toxin to a facility eligible for receiving them or destroys them onsite is not required to make a report. Proper destruction of the agent must take place through autoclaving, incineration, or by a sterilization or neutralization process sufficient to cause inactivation. The transfer or destruction must occur within seven calendar days after identification of a select agent or toxin used for diagnosis or testing and within 90 calendar days after receipt for proficiency testing.

Any additional exemptions from reporting under 42 CFR 73.6, including subsequent amendments and editions, are also exempt from reporting under this regulation; however, the department must be notified of the exemption by submitting a copy of federal forms addressing the exemption within seven calendar days of submission to the CDC Select Agent Program.

12VAC5-90-360. Release of reported information. (Repealed.)

Reports submitted to the select agent and toxin registry shall be confidential and shall not be a public record pursuant to

the Freedom of Information Act. Release of information on select agents or toxins shall be made only by order of the State Health Commissioner to the CDC and state and federal law enforcement agencies in any investigation involving the release, theft, or loss of a select agent or toxin required to be reported to the department under this regulation.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC5-90)

~~Virginia Department of Health Confidential Morbidity Report, Epi 1 (rev. 3/07)~~

[Confidential Morbidity Report, Epi-1 \(rev. 10/11\)](#)

Virginia Cancer Registry Reporting Form (rev. 1/98)

DOCUMENTS INCORPORATED BY REFERENCE (12VAC5-90)

~~Control of Communicable Diseases Manual, 18th Edition, American Public Health Association, 2004.~~

[Control of Communicable Diseases Manual, 20th Edition, 2015, American Public Health Association](#)

VA.R. Doc. No. R13-3366; Filed August 19, 2016, 3:15 p.m.

Proposed Regulation

Title of Regulation: 12VAC5-490. Virginia Radiation Protection Regulations; Fee Schedule (amending 12VAC5-490-10, 12VAC5-490-20).

Statutory Authority: § 32.1-229.1 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: November 18, 2016.

Agency Contact: Steve Harrison, Director, Division of Radiological Health, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-8151, FAX (804) 864-8155, or email steve.harrison@vdh.virginia.gov.

Basis: Section 32.1-229.1 of the Code of Virginia authorizes the State Board of Health to set fees for x-ray equipment and requires the State Board of Health to promulgate regulations for the registration, inspection, and certification of x-ray machines by Department of Health personnel (except for audit inspections initiated by the department). Section 32.1-229.2 of the Code of Virginia requires the State Board of Health to set inspection fees to minimize competition with the private sector and include all reasonable costs.

Purpose: The proposed regulatory action addresses two sets of fees levied by the x-ray machine program: x-ray machine registration fees and x-ray machine inspection fees.

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Radiological control program regulations currently require the registration of nonmedical x-ray equipment (i.e., baggage, cabinet or analytical, and industrial equipment) but do not establish a fee for registration of this equipment, do not establish a fee for the Office of Radiological Health (ORH) to inspect this equipment, and do not specify associated inspection frequencies. Registration and inspection fees for x-ray equipment not used in the healing arts are charged in other states.

The harmful effects of radiation are well known, as well as the many beneficial applications of radiation in industry and health care. Adequate regulatory controls for the useful application of radiation are necessary to protect the health, safety, and welfare of citizens. The potential exists for accidents associated with this equipment, which have in fact occurred. Accordingly, regulatory attention needs to be applied to promote the safety of nonmedical x-ray equipment. These fees will help offset the cost of administrative activities involved in the registration, inspection, and certification of nonmedical x-ray equipment. These costs were once absorbed from general funds allocated to ORH, but those general funds have since been abolished.

Substance: In 12VAC5-490-10, the fee for each machine and additional tubes that has an inspection frequency of every three years is proposed to increase from \$50 to \$60, collected every three years.

The following annual registration fees are proposed for all operators or owners of baggage, cabinet or analytical, or industrial x-ray machines capable of producing radiation:

- \$20 for each machine used for baggage inspection;
- \$25 for each machine identified as cabinet or analytical; and
- \$50 for each machine used for industrial radiography.

The amendments to 12VAC5-490-20 add the following inspection fees and required inspection frequencies for operators or owners of baggage, cabinet or analytical, or industrial x-ray machines capable of producing radiation:

- Baggage x-ray unit: \$100 per inspection, inspected every five years;
- Cabinet/analytical x-ray unit: \$150 per inspection, inspected every three years; and
- Industrial radiography x-ray unit: \$200 per inspection, inspected annually.

Issues: The primary advantage of this change to the public and the regulated community is that registering all x-ray machines allows ORH to maintain an accurate database of the devices, track inspections, and ensure that the machines are functioning properly so as to minimize the risk of equipment malfunction and accidental overexposures.

The primary advantage to the public is that the x-ray machine registration and inspection fees rely on owners or operators of

the x-ray equipment. There are no disadvantages to the public in promulgating the proposed fee schedule.

The advantage to the agency and Commonwealth is that approving the proposed fee structure will allow the Commonwealth to recover more of the costs associated with carrying out the legislative mandate. There are no disadvantages to the agency and Commonwealth in promulgating the proposed fee schedule. The other pertinent matter of interest to the regulated community is that x-ray machine registrants have an interest in keeping inspection fees as low as possible.

Private inspectors of x-ray machines have an interest in ensuring that inspection fees by agency inspectors do not hurt their businesses by undercutting the private sector pricing, and § 32.1-229.2 of the Code of Virginia requires the agency to establish inspection fees in such a manner so as to minimize competition with the private inspector while recovering costs.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Board of Health (Board) proposes to amend the registration fee for x-ray machines inspected every three years and add three new fee categories for the annual registration and periodic inspection of non-medical x-ray devices.

Result of Analysis. Benefits likely outweigh costs for these proposed changes.

Estimated Economic Impact. Current regulation requires owners of medical use x-ray machines and tubes that need to be inspected every three years to pay a registration fee of \$50 every three years. The Board proposes to raise this fee to \$60 every three years because costs for administering this program have increased. This change will minimally increase costs for owners of such machines (by about \$3 per year per machine and tube) but the costs of this change are likely outweighed by the benefits of periodically ensuring that x-ray machines are in safe working order.

Although all owners of x-ray machines that are located in the Commonwealth, and are not under the auspices of the federal government,¹ are required to register such machines with the Virginia Department of Health (VDH), currently only owners of medical use x-ray machines are required to pay a registration fee and an inspection fee (if VDH is the entity that completes the inspection). The Board proposes to add three categories of registration and inspection fees for VDH inspections that will apply to owners of non-medical use x-ray machines. The Board proposes to require an annual registration fee of \$20 for each x-ray machine used for baggage inspection, \$25 for each x-ray machine that is identified as cabinet or analytical² and \$50 for each x-ray machine used for industrial radiography³.

Additionally, the Board proposes to add inspection fees and required inspection intervals for non-medical x-ray machines. Baggage x-ray units will be required to be inspected every five years and will be subject to an inspection fee of \$100 if they are inspected by VDH. Cabinet/analytical x-ray units will be required to be inspected every three years and will be subject to an inspection fee of \$150 if they are inspected by VDH. Industrial radiography x-ray machines will be required to be inspected every year and will be subject to an inspection fee of \$200 if they are inspected by VDH. Board staff reports that about 85% of medical x-ray machine inspections are completed by private businesses rather than VDH, that they expect that most inspections of non-medical x-ray machines will also be completed privately and that the Board does not have estimates of how private inspection fees will compare to those charged by VDH. However, Board staff also reports that fees for private inspection of medical use x-ray machines are generally higher than those charged by VDH for inspecting any given category of machine.

Owners of non-medical x-ray machines that are not local or state governments⁴ will newly incur annual registration costs on account of this proposal. Owners of non-medical x-ray machines will only newly incur costs for inspections to the extent that they were not already being inspected at intervals newly required by the Board. These costs are likely outweighed by the benefits of periodically ensuring that x-ray machines are in safe working order.

Businesses and Entities Affected. Board staff reports that this proposed regulation will affect all owners or medical use x-ray devices that require inspection every three years as well as all owners of non-medical x-ray machines. Board staff further reports that there are currently 630 non-medical facilities with 1,597 x-ray machines; of these, 190 facilities are state or local government entities, 110 are likely small businesses and the remaining 330 are private businesses that would not qualify as small businesses.

Localities Particularly Affected. No locality will be particularly affected by this regulatory change.

Projected Impact on Employment. This proposed regulatory change is unlikely to have any impact on employment in the Commonwealth.

Effects on the Use and Value of Private Property. This proposed regulation is unlikely to have any impact on the use or value of private property.

Real Estate Development Costs. This proposed regulation is unlikely to affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. Affected non-medical small businesses will incur costs for annual registration, and period inspection, of any x-ray machines that they own. Affected medical small businesses will incur an additional \$10 cost every three years for registration of each x-ray machine and additional tube that they own.

Alternative Method that Minimizes Adverse Impact. There are likely no alternative methods that would both satisfy the Board's aim of ensuring x-ray machine safety and further minimize costs.

Adverse Impacts:

Businesses. Affected non-medical businesses will incur costs for annual registration, and period inspection, of any x-ray machines that they own. Affected medical businesses will incur an additional \$10 cost every three years for registration of each x-ray machine and additional tube that they own.

Localities. Affected localities will incur costs for required inspections only to the extent that they are not already inspecting these machines at the required intervals proposed in this regulation, but will not incur registration fees.

Other Entities. No other entities are likely to suffer any adverse impact on account of this proposed regulation.

¹Airports are under federal auspices and are exempt from this regulation.

²Industries that engage in research and development would be one example of this.

³Industrial radiography is a method of inspecting materials for hidden flaws by using the ability of short X-rays and gamma rays to penetrate various materials. Two ways to inspect materials for flaws is to utilize X-ray computed tomography or industrial computed tomography scanning.

⁴State and local governments that have x-ray machines in places like schools, courthouses, jails and prisons are exempt from the Board's proposed registration fees but still must pay for periodic inspections of these machines.

Agency's Response to Economic Impact Analysis: The Virginia Department of Health, Office of Radiological Health concurs with the Virginia Department of Planning and Budget's economic impact analysis.

Summary:

The proposed amendments (i) raise the registration fee for x-ray machines and additional tubes inspected every three years; (ii) add three categories (baggage, cabinet or analytical, and industrial), associated fees, and frequency for the registration of nonmedical x-ray equipment; and (iii) add three categories (baggage, cabinet or analytical, and industrial) and associated fees for the inspection of nonmedical x-ray equipment.

12VAC5-490-10. Registration fees.

A. All operators or owners of diagnostic ~~X-ray~~ x-ray machines used in the healing arts and capable of producing radiation shall pay the following registration fee:

1. \$50 for each machine and additional tube(s) that have a required annual inspection, collected annually; and

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\$50 2. \$60 for each machine and additional tube(s) that have a required inspection every three years, collected every three years.

B. All operators or owners of therapeutic ~~X-ray~~ x-ray, particle accelerators, and teletherapy machines used in the healing arts capable of producing radiation shall pay the following annual registration fee:

1. \$50 for each machine with a maximum beam energy of less than 500 KVp;
2. \$50 for each machine with a maximum beam energy of 500 KVp or greater.

C. All operators or owners of baggage, cabinet or analytical, or industrial x-ray machines capable of producing radiation shall pay the following annual registration fee:

1. \$20 for each machine used for baggage inspection;
2. \$25 for each machine identified as cabinet or analytical; and
3. \$50 for each machine used for industrial radiography.

D. Where the operator or owner of the aforementioned machines is a state agency or local government, that agency is exempt from the payment of the registration fee.

12VAC5-490-20. Inspection fees and inspection frequencies for x-ray machines.

The following table lists the fees that shall be charged for surveys requested by the registrant and performed by a Department of Health inspector, as well as the required inspection frequencies for each type of x-ray machine:

Type	Cost Per Tube	Inspection Frequency
General Radiographic (includes: Chiropractic and Special Purpose X-ray Systems)	\$230	<u>Annually</u>
Fluoroscopic, C-arm Fluoroscopic	\$230	<u>Annually</u>
Combination (General Purpose-Fluoroscopic)	\$460	<u>Annually</u>
Dental Intraoral and Panoramic	\$90	<u>Every 3 years</u>
Veterinary	\$160	<u>Every 3 years</u>
Podiatric	\$90	<u>Every 3 years</u>
Cephalometric	\$120	<u>Every 3 years</u>
Bone Densitometry	\$90	<u>Every 3 years</u>
Combination (Dental Panoramic and Cephalometric)	\$210	<u>Every 3 years</u>

Shielding Review for Dental Facilities	\$250	<u>Initial/Prior to use</u>
Shielding Review for Radiographic, Chiropractic, Veterinary, Fluoroscopic, or Podiatric Facilities	\$450	<u>Initial/Prior to use</u>
<u>Baggage X-ray Unit</u>	<u>\$100</u>	<u>Every 5 years</u>
<u>Cabinet or Analytical X-ray Unit</u>	<u>\$150</u>	<u>Every 3 years</u>
<u>Industrial Radiography X-ray Unit</u>	<u>\$200</u>	<u>Annually</u>

VA.R. Doc. No. R16-4550; Filed August 19, 2016, 3:48 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Final Regulation

REGISTRAR'S NOTICE: The following regulatory action is exempt from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 c of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Department of Medical Assistance Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **12VAC30-10. State Plan under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12VAC30-10-520).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Date: October 19, 2016.

Agency Contact: Emily McClellan, Regulatory Supervisor, Department of Medical Assistance Services, Policy Division, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Summary:

The amendments provide that the Department of Medical Assistance Services will conduct provider screening and terminate or deny enrollment to providers according to federal requirements.

12VAC30-10-520. Required provider agreement.

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

A. For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

B. For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and § 1919 of the Act are also met. (*plus additional requirements described below)

C. For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

D. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

E. For each provider receiving funds under the plan, all the requirements for advance directives of ~~Section~~ § 1902(w) are met:

1. Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State state law (whether statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

2. Providers will furnish the written information described in subdivision E 1 (a) of this section to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

3. 12VAC30-20-240 describes law of the State state (whether statutory or as recognized by the courts of the State state) concerning advance directives.

As a condition of participation in the Virginia Medical Assistance Program all nursing homes must agree that when a patient is discharged to a hospital, the nursing home from which the patient is discharged shall ensure that the patient shall be given an opportunity to be readmitted to the facility at the time of the next available vacancy.

The only acceptable reasons for failure to readmit a specific patient who has been discharged to a hospital shall be the patient is certified for a level of care not provided by the facility, the patient is judged by a physician to be a danger to himself or others, or the patient, who at the time of readmission has an outstanding payment to the nursing home for which he is responsible in accordance with Medicaid regulations.

F. The Department of Medical Assistance Services (DMAS) shall conduct provider screening according to the requirements of Subpart E of 42 CFR Part 455. DMAS shall terminate or deny enrollment to any provider in accordance with the requirements of 42 CFR 455.416.

VA.R. Doc. No. R17-4646; Filed August 26, 2016, 11:36 a.m.

Proposed Regulation

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-130).**

12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-25).

12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-201, 12VAC30-70-321; adding 12VAC30-70-415, 12VAC30-70-417).

12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-21).

12VAC30-130. Amount, Duration and Scope of Selected Services (amending 12VAC30-130-850, 12VAC30-130-890).

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: November 19, 2016.

Agency Contact: Emily McClellan, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmass.virginia.gov.

Basis: Item 307 CCC of Chapter 3 of the 2012 Acts of the Assembly, Special Session I, directed the Department of Medical Assistance Services (DMAS) to develop changes to

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requirements for nonfacility services furnished to individuals residing in institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) in order to comply with federal law. Item 307 CCC of Chapter 806 of the 2013 Acts of the Assembly directed DMAS to require that institutions that treat mental diseases provide referral services to their inpatients when the inpatients need services and to document such referrals and receipt of nonfacility services.

Item 301 XX of Chapter 3 of the 2014 Acts of the Assembly directed DMAS to revise reimbursement for services furnished Medicaid members in residential treatment centers and freestanding psychiatric hospitals to include professional, pharmacy, and other services to be reimbursed separately as long as the services are in the plan of care developed by the residential treatment center or the freestanding psychiatric hospital and arranged by the residential treatment center or the freestanding psychiatric hospital. The same authority exists in the Item XX of Chapter 665 of the 2015 Acts of the Assembly.

Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

Purpose: The U.S. Department of Health and Human Services Office of Inspector General (OIG) audited DMAS' claims for nonfacility services furnished to individuals younger than 21 years of age who reside in inpatient psychiatric facilities (IPFs) and issued its report on March 17, 2004. The report concluded that DMAS must refund to the Centers for Medicare and Medicaid Services (CMS) \$3.9 million for disallowed claims (mostly physician and pharmacy claims) for services furnished to children who resided in IPFs from July 1, 1997, through June 30, 2001, because these services were not part of the allowable inpatient psychiatric benefit. These services were not included in the reimbursement rates for the IPFs but were billed and paid separately to other providers of services.

Based on the OIG report, CMS issued a disallowance on February 29, 2008. DMAS appealed the CMS disallowance but each appeal was denied resulting in a final decision being issued by the U.S. Court of Appeals on May 8, 2012.

In response to that decision, and in accordance with CMS guidance on the inpatient psychiatric benefit, DMAS implemented emergency regulations to permit separate billing for services (referred to by CMS and in the regulations as "services provided under arrangement") when rendered to members under 21 years of age in IPFs when the IPF (i) arranges for and oversees the provision of all services,

including services furnished through contracted providers; (ii) maintains all records of medical care furnished to these individuals; and (iii) ensures that all services are furnished under the direction of a physician.

DMAS will continue to enforce the requirement that written plans of care for individuals in IPFs be comprehensive, covering medical, psychological, social, behavioral, and developmental needs (including emergency services). In addition, the previous emergency regulations, as well as these proposed regulations will require IPFs to (i) contract with non-employee providers of services under arrangement (to the extent non-employee providers are providing services under arrangement); (ii) make referrals to employee and contracted providers of services provided under arrangement; and (iii) obtain and maintain medical records from all providers of services provided under arrangement that are not covered by the facility's per diem. If these requirements are met, DMAS will continue to directly reimburse providers of services under arrangement using existing reimbursement methodologies.

These regulations will have no effect on the health, safety or welfare of either Medicaid eligible individuals or on citizens of the Commonwealth.

Substance: The sections of the State Plan for Medical Assistance that are affected by this action are (i) Amount, Duration, and Scope of Medical and Remedial Services Provided to Categorically/Medically Needy Individuals-EPSDT Services (12VAC30-50-130); (ii) Standards Established and Methods Used to Assure High Quality of Care (Utilization control: freestanding psychiatric hospitals (12VAC30-60-25)); (iii) Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (12VAC30-70-201, 12VAC30-70-321, 12VAC30-70-415, and 12VAC30-70-417); and (iv) Methods and Standards for Establishing Payment Rates-Other Types of Providers (inpatient psychiatric services in residential treatment facilities (under EPSDT (12VAC30-80-21))). The state-only regulations that are affected by this action are Residential Psychiatric Treatment for Children and Adolescents (plans of care; review of plans of care (12VAC30-130-850 through 12VAC30-130-890)).

Prior to the emergency regulations, DMAS paid separately for professional services, such as physician or pharmacy services, that were furnished in facilities (hospitals, nursing facilities, residential treatment centers, etc.) to inpatients or residents. At that time, each provider was only required to maintain records for the services they furnished directly. The facilities (hospitals, nursing facilities, and residential treatment centers) were not required to make referrals for or maintain results of these services.

When a child is in an inpatient psychiatric facility (either freestanding public or private psychiatric hospitals or residential treatment centers), under CMS interpretation as a result of the referenced court order, these separate payments

to the providers of professional services and for drugs are not eligible for federal Medicaid matching funds unless the services are part of the inpatient psychiatric benefit. To be part of the inpatient psychiatric benefit and eligible for federal Medicaid matching funds, the IPF must oversee and arrange for these services, maintain the medical records of care furnished to these individuals, and ensure that services are furnished under the direction of a physician. If these requirements are met, DMAS may continue to directly reimburse providers of services under arrangement using existing reimbursement methodologies.

Certain services are already covered by these facilities' per diem payments. Therefore, the list of services provided under arrangement affected by this proposed regulation varies by each facility type (state freestanding psychiatric hospital, private freestanding psychiatric hospital, and residential treatment center).

The following chart lists the services provided under arrangement that may be billed separately for each provider type, provided that the requirements discussed are met. No other services may be billed for members under 21 years of age residing in IPFs.

Services Provided Under Arrangement	Residential Treatment Centers - Level C	Private Freestanding Psychiatric Hospitals	State Freestanding Psychiatric Hospitals
Physician services	Yes	Yes	No
Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e., oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	Yes	No
Outpatient hospital services	Yes	Yes	No
Pharmacy services	Yes	No	Yes
Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	Yes	No
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	Yes	No	No
Vision services	Yes	Yes	No
Dental and orthodontic services	Yes	Yes	No
Nonemergency transportation services	Yes	Yes	No
Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes	Yes

Issues: There are no advantages or disadvantages to private citizens in these changes. The primary advantages to the agency and the Commonwealth are that these changes will comport with federal requirements as a result of the lawsuit. These changes could be seen as a disadvantage to institutions that treat mental disease and providers of services under arrangement because of the additional referral and service documentation requirements but the changes are necessary to continue to use Medicaid funds to reimburse for these services.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. As the result of a federal court decision,¹ the Department of Medical Assistance Services (DMAS) proposes to change the requirements for inpatient psychiatric facilities (IPFs) and for providers that offer certain services (such as physician services, medical and psychologic services, vision, dental and emergency services) to residents of IPFs.

Result of Analysis. The benefits likely exceed the costs for all proposed changes.

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Estimated Economic Impact. The U.S. Department of Health and Human Services Office of Inspector General (OIG) audited DMAS' claims for non-facility services furnished to individuals younger than 21 years of age who reside in IPFs and issued its report on March 17, 2004. The report concluded that DMAS must refund to the federal Centers for Medicare & Medicaid Services (CMS) \$3.9 million for disallowed claims (mostly physician and pharmacy claims) for services furnished to children who resided in IPFs from July 1, 1997 through June 30, 2001 because these services were not part of the allowable inpatient psychiatric benefit. These services were not included in the reimbursement rates for the IPFs but were billed and paid separately to other providers of services.

Based on the OIG report, CMS issued a disallowance on February 29, 2008. DMAS appealed the CMS disallowance but each appeal was denied resulting in a final decision being issued by the U.S. Court of Appeals on May 8, 2012.

In response to that decision, and in accordance with CMS' guidance on the inpatient psychiatric benefit, DMAS implemented emergency regulations to permit separate billing for services (referred to by CMS and in the regulations as "services provided under arrangement") when rendered to members under age 21 in IPFs when the IPF: i) arranges for and oversees the provision of all services, including services furnished through contracted providers; ii) maintains all records of medical care furnished to these individuals; and iii) ensures that all services are furnished under the direction of a physician. DMAS proposes to make the amendments made in the emergency regulation permanent.²

The proposed amendments are necessary in order to continue to use federal Medicaid funds to reimburse for the IPF services detailed above. DMAS receives and passes on to the IPFs approximately \$25 million from CMS annually. The proposed amendments require additional IPF staff time for records keeping, billing, physician oversight, and time educating and attempting to obtain contracts from providers in the community in a timely manner. Based on a small survey of IPFs, the proposed requirements in effect currently under the emergency regulation have cost IPFs approximately \$50,000 to \$150,000 (on annual basis) per facility for additional required staff time. There are 29 IPFs in the Commonwealth. Thus the proposed requirements increase costs statewide by approximately \$1.45 million to \$4.35 million. The proposed amendments do produce a net benefit in that they help ensure that approximately \$25 million in federal dollars are received for IPF services, whereas the cumulative cost of the additional staff time is less than \$5 million.

Businesses and Entities Affected. The proposed amendments affect the approximately 21 residential treatment centers, 6 private psychiatric hospitals, and 2 state facilities serving members under the age of 21 in the Commonwealth, and numerous providers of services under arrangement

(physicians, psychologists, pharmacies, outpatient hospitals, dentists, etc.).

Localities Particularly Affected. The proposed amendments do not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendments increase staffing needs for inpatient psychiatric facilities.

Effects on the Use and Value of Private Property. The proposed amendments require private inpatient psychiatric facilities to employ additional staff hours. This may moderately reduce their value. The proposed amendments are necessary in order to continue to receive federal funding that exceeds the increased cost of additional staff time.

Real Estate Development Costs. The proposed amendments do not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. The 21 residential treatment centers are likely small businesses. The proposed amendments increase costs for the residential treatment centers through required additional staff time.

Alternative Method that Minimizes Adverse Impact. The proposed amendments are necessary in order to continue to receive federal funding that exceeds the increased cost of additional staff time. Thus there is no alternative method that minimizes adverse impact.

Adverse Impacts:

Businesses. The proposed amendments increase costs for the residential treatment centers and private psychiatric hospitals through required additional staff time.

Localities. The proposed amendments do not adversely affect localities.

Other Entities. The proposed amendments increase costs for the two affected state facilities through required additional staff time.

¹See [https://www.cadc.uscourts.gov/internet/opinions.nsf/0B411CD77E39203C852579F8004E388A/\\$file/11-5161-1372715.pdf](https://www.cadc.uscourts.gov/internet/opinions.nsf/0B411CD77E39203C852579F8004E388A/$file/11-5161-1372715.pdf).

²There are minor wording differences in this proposed regulation versus the emergency regulation. The differences do not substantially change requirements.

Agency's Response to Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning the Institutions for Mental Disease Reimbursement Changes. The agency raises no issues with this analysis

Summary:

As a result of a federal court decision, the Department of Medical Assistance Services (DMAS) proposes to change the requirements for inpatient psychiatric facilities (IPFs) and providers that offer certain services, such as physician, medical, psychological, vision, dental, and emergency services, to residents of IPFs. The affected IPFs are state freestanding psychiatric hospitals, private freestanding psychiatric hospitals, and residential treatment facilities (Level C). Item 307 CCC of Chapter 3 of the 2012 Acts of the Assembly, Special Session I, directs DMAS to develop changes to requirements for nonfacility services furnished to individuals residing in IPFs to comply with the court order and a prospective payment methodology to reimburse institutions treating mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others.

Item 307 CCC of Chapter 806 of the 2013 Acts of the Assembly directs DMAS to require that institutions that treat mental diseases provide referral services to their inpatients when an inpatient needs ancillary services. Item 301 XX of Chapter 3 of the 2014 Acts of the Assembly, Special Session I, and Item 301 XX of Chapter 665 of the 2015 Acts of the Assembly direct DMAS to revise reimbursement for services furnished to Medicaid members in residential treatment centers and freestanding psychiatric hospitals to include professional, pharmacy, and other services to be reimbursed separately as long as the services are in the plan of care developed by the residential treatment center or the freestanding psychiatric hospital and arranged by the residential treatment center or the freestanding psychiatric hospital.

The amendments conform the regulations to these requirements.

12VAC30-50-130. ~~Skilled nursing~~ Nursing facility services, EPSDT, including school health services and family planning.

A. ~~Skilled nursing~~ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and

treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by ~~the Act~~ § 1905(a) of the Social Security Act.

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescriber" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and

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treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"EPSDT" means early and periodic screening, diagnosis, and treatment.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors

for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of

accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"Services provided under arrangement" means the same as defined in 12VAC30-130-850.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the

home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(4) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

c. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

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d. Community-based services for children and adolescents under 21 years of age (Level A) pursuant to 42 CFR 440.130(d).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), ~~Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51)~~ Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B) pursuant to 42 CFR 440.130(d).

(1) Such services must be therapeutic services rendered in a residential setting that ~~provides~~ provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living

skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2) for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by: ~~a. A~~ (i) a psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or (ii) a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations; or the Commission on Accreditation of Rehabilitation Facilities; the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership. ~~b.~~ Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of ~~Amount, Duration and Scope of Selected Services~~ 12VAC30-130.

a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160 that are provided under the direction of a physician pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals

and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

b. Eligible services provided under arrangement with the inpatient psychiatric facility shall vary by provider type as described in this subsection. For purposes of this section, emergency services means the same as is set out in 12VAC30-50-310 B.

(1) State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) pharmacy services and (ii) emergency services.

(2) Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

(3) Residential treatment facilities, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

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c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with (i) 42 CFR Part 441 Subpart D, as contained in specifically 42 CFR 441.151(a) and (b) and 441.152 through 441.156, and (ii) the conditions of participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

d. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services; shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education; and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers; but

may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services;

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for

purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D (12VAC30-50-530). Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

D. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

12VAC30-60-25. Utilization control: freestanding psychiatric hospitals.

A. Psychiatric services in freestanding psychiatric hospitals shall only be covered for eligible persons younger than 21 years of age and older than 64 years of age.

B. Prior authorization required. DMAS shall monitor, consistent with state law, the utilization of all inpatient freestanding psychiatric hospital services. All inpatient hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

C. All Medicaid services are subject to utilization review and audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement. In each case for which payment for freestanding psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a freestanding psychiatric hospital consistent with 42 CFR 456.160.

2. The physician, physician assistant, or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify at least every 60 days that the individual continues to require inpatient services in a psychiatric hospital.

3. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must perform a medical evaluation of the individual and appropriate professional personnel must make a psychiatric and social evaluation as cited in 42 CFR 456.170.

4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each recipient patient as cited in 42 CFR 441.155 and 456.180. The plan shall also include a list of services provided under written contractual arrangement with the

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freestanding psychiatric hospital (see 12VAC30-50-130) that will be furnished to the patient through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

D. If the eligible individual is 21 years of age or older, then, in order to qualify for Medicaid payment for this service, he must be at least 65 years of age.

E. If younger than 21 years of age, it shall be documented that the individual requiring admission to a freestanding psychiatric hospital is under 21 years of age, that treatment is medically necessary, and that the necessity was identified as a result of an early and periodic screening, diagnosis, and treatment (EPSDT) screening. Required patient documentation shall include, but not be limited to, the following:

1. An EPSDT physician's screening report showing the identification of the need for further psychiatric evaluation and possible treatment.
2. A diagnostic evaluation documenting a current (active) psychiatric disorder included in the DSM-III-R that supports the treatment recommended. The diagnostic evaluation must be completed prior to admission.
3. For admission to a freestanding psychiatric hospital for psychiatric services resulting from an EPSDT screening, a certification of the need for services as defined in 42 CFR 441.152 by an interdisciplinary team meeting the requirements of 42 CFR 441.153 or 441.156 and ~~the~~ The Psychiatric Inpatient Treatment of Minors Act (§ 16.1-335 et seq. of the Code of Virginia).

F. If a Medicaid eligible individual is admitted in an emergency to a freestanding psychiatric hospital on a Saturday, Sunday, holiday, or after normal working hours, it shall be the provider's responsibility to obtain the required authorization on the next work day following such an admission.

G. The absence of any of the required documentation described in this subsection shall result in DMAS' denial of the requested preauthorization and coverage of subsequent hospitalization.

F. H. To determine that the DMAS enrolled mental hospital providers are in compliance with the regulations governing mental hospital utilization control found in the 42 CFR 456.150, an annual audit will be conducted of each enrolled hospital. This audit may be performed either on site or as a desk audit. The hospital shall make all requested records available and shall provide an appropriate place for the auditors to conduct such review if done on site. The audits shall consist of review of the following:

1. Copy of the mental hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR 456.200 through 456.245.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR 456.205 and 456.206.

3. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the committee is meeting according to their utilization management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with 42 CFR 456.241 through 456.245.

5. Topic of one ongoing Medical Care Evaluation Study to determine the hospital is in compliance with 42 CFR 456.245.

6. From a list of randomly selected paid claims, the freestanding psychiatric hospital must provide a copy of the certification for services, a copy of the physician admission certification, a copy of the required medical, psychiatric, and social evaluations, and the written plan of care for each selected stay to determine the hospital's compliance with §§ 16.1-335 through 16.1-348 of the Code of Virginia and 42 CFR 441.152, 456.160, 456.170, 456.180 and 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

I. The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:

1. The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;

2. The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;

3. The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

4. The referral to the service provided under arrangement was not present in the patient's freestanding psychiatric hospital record;

5. The service provided under arrangement was not supported in that provider's records by a documented referral from the freestanding psychiatric hospital;

6. The medical records from the provider of services under arrangement (i.e., admission and discharge documents, treatment plans, progress notes, treatment summaries, and documentation of medical results and findings) (i) were not

present in the patient's freestanding psychiatric hospital record or had not been requested in writing by the freestanding psychiatric hospital within seven days of completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of completion of the service or services, but had not been received within 30 days of the request, and had not been re-requested;

7. The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services hospital provider prior to submission of the ancillary provider's claim for payment.

J. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.

K. The hospitals may appeal in accordance with the Administrative Process Act (§ ~~9-6.14.1~~ 2.2-4000 et seq. of the Code of Virginia) any adverse decision resulting from such audits ~~which that~~ results in retraction of payment. The appeal must be requested ~~within 30 days of the date of the letter notifying the hospital of the retraction~~ pursuant to the requirements of 12VAC30-20-500 et seq.

Part V
Inpatient Hospital Payment System
Article 1
Application of Payment Methodologies

12VAC30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) of this part describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) of this part describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998; and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs except for inpatient psychiatric services furnished under early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals

younger than age 21. These inpatient services shall be reimbursed according to 12VAC30-70-415 and shall be provided according to the requirements set forth in 12VAC30-50-130 and 12VAC30-60-25 H. Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection F of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre-hospitalization and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

E. Reduction of payments methodology.

1. For state fiscal years 2003 and 2004, the Department of Medical Assistance Services (DMAS) shall reduce payments to hospitals participating in the Virginia Medicaid Program by \$8,935,825 total funds, and \$9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the total reduction amount shall be determined as provided in this subsection.

2. Determine base for revenue forecast.

a. DMAS shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and outpatient reimbursed cost, as recorded by DMAS for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated statewide HMO average percentage of Medicaid business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.

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b. For freestanding psychiatric hospitals, DMAS shall use estimated Medicaid revenues for the six-month period (January 1, 2001, through June 30, 2001), times two, and adjusted for inflation by 4.3% for state fiscal year 2002, 3.1% for state fiscal year 2003, and 3.7% for state fiscal year 2004, as reported by DRI-WEFA, Inc.'s, hospital input price level percentage moving average.

3. Determine forecast revenue.

a. Each Type I hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 a of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type I hospitals.

b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type II hospitals.

4. Each hospital's total yearly reduction amount is equal to ~~their~~ its respective state fiscal year 2003 and 2004 forecast reimbursement as described in subdivision 3 of this subsection, times 3.235857% for state fiscal year 2003, and 3.235857%, for the first two quarters of state fiscal year 2004 and 2.88572% for the last two quarters of state fiscal year 2004, not to be reduced by more than \$500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in subdivision 4 of this subsection. Payment reduction offsets not covered by claims remittance by May 15, 2003, and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30, 2003, or 2004, as applicable.

F. Consistent with 42 CFR 447.26 and effective July 1, 2012, the Commonwealth shall not reimburse inpatient hospitals for provider-preventable conditions (PPCs), which include:

1. Health care-acquired conditions (HCACs). HCACs are conditions occurring in any hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

2. Other provider preventable conditions (OPPCs) as follows: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; or (iii)

surgical or other invasive procedure performed on the wrong patient.

12VAC30-70-321. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12VAC30-70-341, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per day.

B. For rural hospitals, the hospital's Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

C. Effective July 1, 2008, and ending after June 30, 2010, the hospital specific operating rate per day shall be reduced by 2.683%.

~~D. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.~~

~~E. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.~~

~~F. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.~~

~~G. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from Medicare cost report.~~

12VAC30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.

A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12VAC30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-

standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio total of capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in 12VAC30-80 or elsewhere in the State Plan, to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in subdivision C 4 of 12VAC30-60-25; and
2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

12VAC30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.

A. Effective January 1, 2000, DMAS shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by DMAS based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all services provided under arrangement that are reimbursed in the manner described in subsection D of this section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by DMAS at such time as required by DMAS. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, DMAS shall take action in accordance with its policies to assure that an overpayment is not being made.

D. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS to a provider of services provided under arrangement according to the reimbursement methodology prescribed for that provider type elsewhere in the State Plan if all of the following are met:

1. The services provided under arrangement are included in the active written treatment plan of care developed and signed as described in section 12VAC30-130-890; and
2. The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for services provided under arrangement.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC30-70)

Computation of Inpatient Operating Cost, HCFA-2552-92 D-1 (12/92).

Apportionment of Cost of Services Rendered by Interns and Residents, HCFA-2552-92 D-2 (12/92).

Cost Reporting Forms for Hospitals (Map 783 Series), eff. 10/15/93

- Certification by Officer or Administrator of Provider
- Analysis of Interim Payments for Title XIX Services
- Computation of Title XIX Ratio of Cost to Charges
- Computation of Inpatient and Outpatient Ancillary Service Costs
- Computation of Outpatient Capital Reduction
- Computation of Title XIX Outpatient Costs
- Computation of Charges for Lower of Cost or Charge Comparison
- Computation of Title XIX Reimbursement Settlement
- Computation of Net Medicaid Inpatient Operating Cost Adjustment
- Calculation of Medicaid Inpatient Profit Incentive for Hospitals
- Plant Costs
- Education Costs
- Obstetrical Care Requirements Certification
- Computation for Separating the Allowable Plant and Education Cost (pass-throughs) from the Inpatient Medicaid Hospital Costs

[Cost Reporting Form Residential Treatment Facilities, RTF-608 \(undated, filed 9/2016\)](#)

12VAC30-80-21. Inpatient psychiatric services in residential treatment facilities (under EPSDT). Reimbursement for services furnished individuals

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residing in a freestanding psychiatric hospital or residential treatment center (Level C).

~~A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.~~

~~B. Methodology. Effective January 1, 2000, payment will be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services.~~

~~C. Data collection. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the Program shall take action in accordance with its policies to assure that an overpayment is not being made.~~

A. Reimbursement for all services furnished to individuals younger than 21 years of age who are residing in a freestanding psychiatric hospital shall be based on the freestanding psychiatric hospital reimbursement described in 12VAC30-70-415 and the reimbursement of services provided under arrangement described in 12VAC30-80.

B. Reimbursement for all services furnished to individuals younger than 21 years of age who are residing in a residential treatment center (Level C) shall be based on the residential treatment center (Level C) reimbursement described in 12VAC30-70-417 and the reimbursement of services provided under arrangement described in 12VAC30-80.

Part XIV

Residential Psychiatric Treatment for Children and Adolescents

12VAC30-130-850. Definitions.

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

"Active treatment" means implementation of a professionally developed and supervised individual plan of care that must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

"Certification" means a statement signed by a physician that inpatient services in a residential treatment facility are or were needed. The certification must be made at the time of admission, or, if an individual applies for assistance while in a mental hospital or residential treatment facility, before the Medicaid agency authorizes payment.

"Comprehensive individual plan of care" or "CIPOC" means a written plan developed for each recipient in accordance with

12VAC30-130-890 to improve his condition to the extent that inpatient care is no longer necessary.

"Emergency services" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Individual" or "individuals" means a child or adolescent younger than 21 years of age who is receiving a service covered under this part of this chapter.

"Initial plan of care" means a plan of care established at admission, signed by the attending physician or staff physician, that meets the requirements in 12VAC30-130-890.

"Inpatient psychiatric facility" or "IPF" means a private or state-run freestanding psychiatric hospital or psychiatric residential treatment center.

"Recertification" means a certification for each applicant or recipient that inpatient services in a residential treatment facility are needed. Recertification must be made at least every 60 days by a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician.

"Recipient" or "recipients" means the child or adolescent younger than 21 years of age receiving this covered service.

"RTC-Level C" means a psychiatric residential treatment facility (Level C).

"Services provided under arrangement" means services including physician and other health care services that are furnished to children while they are in an IPF that are billed by the arranged practitioners separately from the IPF per diem.

12VAC30-130-890. Plans of care; review of plans of care.

A. All Medicaid services are subject to utilization review and audit. The absence of any required documentation may result in denial or retraction of any reimbursement.

B. For Residential Treatment Services (Level C) (RTS-Level C), an initial plan of care must be completed at admission and a Comprehensive Individual Plan of Care (CIPOC) must be completed no later than 14 days after admission.

~~B. C.~~ Initial plan of care (Level C) must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the ~~recipient~~ individual;
3. Treatment objectives with short-term and long-term goals;

4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the ~~patient~~ individual and a list of services provided under arrangement (see 12VAC30-50-130 for eligible services provided under arrangement) that will be furnished to the individual through the RTC-Level C's referral to an employed or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought;

5. Plans for continuing care, including review and modification to the plan of care;

6. Plans for discharge; and

7. Signature and date by the physician.

~~C. D.~~ The CIPOC for Level C must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the ~~recipient's~~ individual's situation and must reflect the need for inpatient psychiatric care;

2. Be developed by an interdisciplinary team of physicians and other personnel specified under subsection ~~F G~~ of this section, who are employed by, or provide services to, patients in the facility in consultation with the ~~recipient~~ individual and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;

3. State treatment objectives that must include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; ~~and~~

5. Include a list of services provided under arrangement (described in 12VAC30-50-130) that will be furnished to the individual through referral to an employee or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought; and

6. Describe comprehensive discharge plans and coordination of inpatient services and post-discharge plans with related community services to ensure continuity of care upon discharge with the ~~recipient's~~ individual's family, school, and community.

~~D. E.~~ Review of the CIPOC for Level C. The CIPOC must be reviewed every 30 days by the team specified in subsection ~~F G~~ of this section to:

1. Determine that services being provided are or were required on an inpatient basis; and

2. Recommend changes in the plan as indicated by the ~~recipient's~~ individual's overall adjustment as an inpatient.

~~E. F.~~ The development and review of the plan of care for Level C as specified in this section satisfies the facility's utilization control requirements for recertification and establishment and periodic review of the plan of care, as required in 42 CFR 456.160 and 456.180.

~~F. G.~~ Team developing the CIPOC for Level C. The following requirements must be met:

1. At least one member of the team must have expertise in pediatric mental health. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of all of the following:

a. Assessing the ~~recipient's~~ individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

b. Assessing the potential resources of the ~~recipient's~~ individual's family;

c. Setting treatment objectives; and

d. Prescribing therapeutic modalities to achieve the plan's objectives.

2. The team must include, at a minimum, either:

a. A board-eligible or board-certified psychiatrist;

b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

3. The team must also include one of the following:

a. A psychiatric social worker;

b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;

c. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals; or

d. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

~~G. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement. H. The RTC-Level C shall not receive a per diem reimbursement for any day that:~~

1. The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement:

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(a) The prescribed frequency of treatment of such service, or includes a frequency that was exceeded; or

(b) All services that the individual needs while residing at the RTC-Level C and that will be furnished to the individual through the RTC-Level C referral to an employed or contracted provider of services under arrangement.

2. The initial or comprehensive written plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

3. The referral to the service provided under arrangement was not present in the individual's RTC-Level C record;

4. The service provided under arrangement was not supported in that provider's records by a documented referral from the RTC-Level C;

5. The medical records from the provider of services under arrangement (i.e., admission and discharge documents, treatment plans, progress notes, treatment summaries, and documentation of medical results and findings) (i) were not present in the individual's RTC-Level C record or had not been requested in writing by the RTC-Level C within seven days of discharge from or completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of discharge from or completion of the service or services provided under arrangement, but not received within 30 days of the request, and not re-requested; or

6. The RTC-Level C did not have a fully executed contract or employee relationship with an independent provider of services under arrangement in advance of the provision of such services. For emergency services, the RTC-Level C shall have a fully executed contract with the emergency services provider prior to submission of the emergency service provider's claim for payment.

7. A physician's order for the service under arrangement is not present in the record.

8. The service under arrangement is not included in the individual's CIPOC within 30 calendar days of the physician's order.

I. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service provided under arrangement that was (i) furnished prior to receiving a referral or (ii) in excess of the amounts in the referral. Providers of services under arrangement shall be required to reimburse DMAS for the cost of any such services provided under arrangement that were rendered in the absence of an employment or contractual relationship.

H. J. For ~~Therapeutic Behavioral Services~~ therapeutic behavioral services for ~~Children~~ children and ~~Adolescents~~ adolescents under 21 (Level B), the initial plan of care must be completed at admission by the licensed mental health professional (LMHP) and a CIPOC must be completed by the

LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.

~~I. K. For ~~Community Based Services~~ community-based services for ~~Children~~ children and ~~Adolescents~~ adolescents under 21 (Level A), the initial plan of care must be completed at admission by the QMHP and a CIPOC must be completed by the QMHP no later than 30 days after admission. The individualized plan of care must be signed and dated by the program director.~~

~~J. L. Initial plan of care for Levels A and B must include:~~

- ~~1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;~~
- ~~2. A description of the functional level of the ~~child~~ individual;~~
- ~~3. Treatment objectives with short-term and long-term goals;~~
- ~~4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;~~
- ~~5. Plans for continuing care, including review and modification to the plan of care; and~~
- ~~6. Plans for discharge.~~

~~K. M. The CIPOC for Levels A and B must meet all of the following criteria:~~

- ~~1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the ~~child's~~ individual's situation and must reflect the need for residential psychiatric care;~~
- ~~2. The CIPOC for both levels must be based on input from school, home, other ~~healthcare~~ health care providers, the ~~child~~ individual and family (or legal guardian);~~
- ~~3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;~~
- ~~4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and~~
- ~~5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the ~~child's~~ individual's family, school, and community.~~

~~L. N. Review of the CIPOC for Levels A and B. The CIPOC must be reviewed, signed, and dated every 30 days by the QMHP for Level A and by the LMHP for Level B. The review must include:~~

- ~~1. The response to services provided;~~
- ~~2. Recommended changes in the plan as indicated by the ~~child's~~ individual's overall response to the plan of care interventions; and~~

3. Determinations regarding whether the services being provided continue to be required.

Updates must be signed and dated by the service provider.

~~M. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.~~

VA.R. Doc. No. R14-3714; Filed August 19, 2016, 3:08 p.m.

Emergency Regulation

Titles of Regulations: 12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (adding 12VAC30-50-455; repealing 12VAC30-50-440, 12VAC30-50-450, 12VAC30-50-490).

12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-360).

12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-110).

12VAC30-120. Waivered Services (amending 12VAC30-120-700, 12VAC30-120-710, 12VAC30-120-750, 12VAC30-120-751, 12VAC30-120-752, 12VAC30-120-754, 12VAC30-120-756, 12VAC30-120-758, 12VAC30-120-759, 12VAC30-120-760, 12VAC30-120-761, 12VAC30-120-762, 12VAC30-120-764, 12VAC30-120-766, 12VAC30-120-770, 12VAC30-120-773, 12VAC30-120-774, 12VAC30-120-775, 12VAC30-120-777, 12VAC30-120-779, 12VAC30-120-1000, 12VAC30-120-1005, 12VAC30-120-1020, 12VAC30-120-1030, 12VAC30-120-1070, 12VAC30-120-1090, 12VAC30-120-1500, 12VAC30-120-1510, 12VAC30-120-1520, 12VAC30-120-1540; adding 12VAC30-120-501, 12VAC30-120-505, 12VAC30-120-514, 12VAC30-120-515, 12VAC30-120-525, 12VAC30-120-535, 12VAC30-120-545, 12VAC30-120-570, 12VAC30-120-580, 12VAC30-120-735, 12VAC30-120-782, 12VAC30-120-1019, 12VAC30-120-1021, 12VAC30-120-1022, 12VAC30-120-1023, 12VAC30-120-1024, 12VAC30-120-1025, 12VAC30-120-1026, 12VAC30-120-1027, 12VAC30-120-1028, 12VAC30-120-1029, 12VAC30-120-1031, 12VAC30-120-1032, 12VAC30-120-1033, 12VAC30-120-1034, 12VAC30-120-1035, 12VAC30-120-1036, 12VAC30-120-1037, 12VAC30-120-1038, 12VAC30-120-1039, 12VAC30-120-1058, 12VAC30-120-1059, 12VAC30-120-1061, 12VAC30-120-1063, 12VAC30-120-1064, 12VAC30-120-1065, 12VAC30-120-1066, 12VAC30-120-1067, 12VAC30-120-1068, 12VAC30-120-1069, 12VAC30-120-1552, 12VAC30-120-1554, 12VAC30-120-1556, 12VAC30-120-1558, 12VAC30-120-1560, 12VAC30-120-1580; repealing 12VAC30-120-720, 12VAC30-120-730, 12VAC30-120-740, 12VAC30-120-753, 12VAC30-120-776, 12VAC30-120-1010, 12VAC30-120-1040, 12VAC30-120-1060, 12VAC30-120-1080, 12VAC30-120-1088, 12VAC30-120-1530, 12VAC30-120-1550).

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396.

Effective Dates: September 1, 2016, through February 28, 2018.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Preamble:

This action concerns the redesign of three of the Department of Medical Assistance Services (DMAS) existing home and community-based waivers: Individual and Family Developmental Disabilities Support Waiver (12VAC30-120-700 et seq.), which is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver (12VAC30-120-1000 et seq.), which is changing to the Community Living Waiver (CL); and the Day Support Waiver for Individuals with Mental Retardation (12VAC30-120-1500 et seq.) is changing to the Building Independence Waiver (BI).

Section 2.2-4011 of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of subdivision A 4 of § 2.2-4006 of the Code of Virginia.

Item 301 MMMM (2) of Chapter 665 of the 2015 Acts of the Assembly directed: "The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on plans to redesign the Medicaid comprehensive Intellectual and Developmental Disability waivers prior to the submission of a request to the Centers for Medicare and Medicaid Services to amend the waivers. In developing the report, the departments shall include plans for the list of services to be included in each waiver, service limitations, provider qualifications, and proposed licensing regulatory changes; and proposed changes to the rate structure for services and the cost to implement such changes. The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on how the individuals currently served in the existing waivers and those expected to transition to the community will be served in the redesigned waivers based on their expected level of need for services."

Item 306 CCC of Chapter 780 of the 2016 Acts of the Assembly directed:

"1. The Department of Medical Assistance Services shall adjust the rates and add new services in accordance with the recommendations of the provider rate study and the published formula for determining the SIS® levels and tiers developed as part of the redesign of the Individual and Family Developmental Disabilities Support (DD),

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Day Support (DS), and Intellectual Disability (ID) Waivers. The department shall have the authority to adjust provider rates and units, effective July 1, 2016, in accordance with those recommendations with the exception that no rate changes for Sponsored Residential services shall take effect until January 1, 2017. The rate increase for skilled nursing services shall be 25 percent."

"2. The Department of Medical Assistance Services shall have the authority to amend the Individual and Family Developmental Disabilities Support (DD), Day Support (DS), and Intellectual Disability (ID) Waivers, to initiate the following new waiver services effective July 1, 2016: Shared Living Residential, Supported Living Residential, Independent Living Residential, Community Engagement, Community Coaching, Workplace Assistance Services, Private Duty Nursing Services, Crisis Support Services, Community Based Crisis Supports, Center-based Crisis Supports, and Electronic Based Home Supports; and the following new waiver services effective July 1, 2017: Community Guide and Peer Support Services, Benefits Planning, and Non-medical Transportation. The rates and units for these new services shall be established consistent with recommendations of the provider rate study and the published formula for determining the SIS levels and tiers developed as part of the waiver redesign, with the exception that private duty nursing rates shall be equal to the rates for private duty nursing services in the Assistive Technology Waiver and the EPSDT program. The implementation of these changes shall be developed in partnership with the Department of Behavioral Health and Developmental Services."

"3. Out of this appropriation, \$328,452 the first year and \$656,903 the second year from the general fund and \$328,452 the first year and \$656,903 the second year from nongeneral funds shall be provided for a Northern Virginia rate differential in the family home payment for Sponsored Residential services. Effective January 1, 2017, the rates for Sponsored Residential services in the Intellectual Disability waiver shall include in the rate methodology a higher differential of 24.5 percent for Northern Virginia providers in the family home payment as compared to the rest-of-state rate. The Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services shall, in collaboration with sponsored residential providers and family home providers, collect information and feedback related to payments to family homes and the extent to which changes in rates have impacted payments to the family homes statewide."

"4. For any state plan amendments or waiver changes to effectuate the provisions of paragraphs CCCC 1 and CCCC 2 above, the Department of Medical Assistance Services shall provide, prior to submission to the Centers for Medicare and Medicaid Services, notice to the Chairmen of the House Appropriations and Senate

Finance Committees, and post such changes and make them easily accessible on the department's website."

"5. The department shall have the authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such changes."

The redesign effort, a collaboration among DMAS, the Department of Behavioral Health and Developmental Services (DBHDS), consultants, and stakeholders for the last two years, combines the target populations of individuals with intellectual disabilities and other developmental disabilities and offers new services that are designed to promote improved community integration and engagement. This purpose of the redesign is to (i) better support individuals with disabilities to live integrated and engaged lives in their communities; (ii) standardize and simplify access to services; (iii) cover services that promote community integration and engagement; (iv) improve providers' capacity and quality by increasing compensation as they increase expertise; (v) achieve better outcomes for individuals supported in smaller community settings; and (vi) facilitate meeting the Commonwealth's commitments under the community integration mandate of the American with Disabilities Act (42 USC § 12101 et seq.), the Supreme Court's Olmstead Decision, and the 2012 U.S. Department of Justice Settlement Agreement.

Significant input throughout the redesign process has been collected from individuals, their families, affected providers, advocates, and other stakeholders as well as national experts. Extensive data has been collected to redesign the current waiver system to more closely link medical/support needs with expenditures. For individuals with intellectual/developmental disabilities and their families, the system will be accessed via a single local point of entry (the Community Services Boards/Behavioral Health Authorities (CSB/BHAs)).

An expanded array of service options over those currently covered in the existing waivers is recommended to enable individuals with disabilities to successfully live in their communities. New services include (i) crisis support (including center-based and community-based) services; (ii) shared living supports; (iii) independent living supports; (iv) supported living residential; (v) community engagement supports; (vi) community coaching supports; (vii) community guide supports; (viii) workplace assistance services; (ix) private duty nursing; and (x) electronic home based supports.

Some currently existing services are being modified and one existing service (prevocational services) is being repealed. Current services include (i) skilled nursing services; (ii) therapeutic consultation; (iii) personal emergency response systems; (iv) assistive technology; (v) environmental modifications; (vi) personal assistance services; (vii) companion services; (viii) respite services;

(ix) group day services; (x) group home services; (xi) sponsored residential services; (xii) individual and family caregiver training; (xiii) supported living; (xiv) supported employment; (xv) transition services; and (xvi) services facilitation.

DMAS and DBHDS recommend retaining the consumer-direction model of service delivery for personal assistance, companion, and respite services as currently permitted with no further expansion of this model to any of the other existing or new services.

In addition to these new services, all individuals will be evaluated with the use of a common assessment instrument (the Supports Intensity Scale (SIS®)) resulting in the development of their unique individual service plans. Seven levels of supports will be established for the purpose of creating the most equitable distribution of funding for core waiver services. Common definitions of intellectual disability and developmental disability are recommended. Standards for a single uniform waiting list are also recommended as well as criteria for how individuals on the waiting list will be provided their choice of available services. Since the target populations of these three waivers are being merged under the single definition of developmental disability, the individual eligibility sections of the regulations are also being merged into a single set of regulations at 12VAC30-120-500 et seq.

DMAS case management regulations (12VAC30-50-440, 12VAC30-50-450, and 12VAC30-50-490) are being repealed and replaced with updated case management regulations to be located at 12VAC30-50-455.

DMAS longstanding regulation titled "Criteria for care in facilities for mentally retarded persons" (12VAC30-60-360) is being renamed "'Criteria for care in facilities for individuals with developmental disabilities." The phrase "or waived rehabilitative services for the mentally retarded" is being removed from 12VAC30-60-360 B relevant to this regulatory action because for this waiver redesign, the level of functioning criteria for institutional services is being replaced with the Virginia Individual Developmental Disabilities Eligibility (VIDES) Survey (for infants, children, and adults) as established in 12VAC30-120-500 et seq. The other changes indicated for 12VAC30-60-360 are technical corrections to update the regulation to the Registrar's current format and labeling standards.

Current policy:

Individual and Family Developmental Disabilities Support (DD) Waiver: This waiver was originally developed in 2000 to serve the needs of individuals, and their families, who require the level of care provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (formerly Intermediate Care Facilities for the Mentally Retarded (ICF/MR)). Such individuals must be older than six years of age and have diagnoses of either autism or severe chronic disabilities

identified in 42 CFR 435.1009 (cerebral palsy or epilepsy, any other condition (other than mental illness) that impairs general intellectual functioning, manifests itself prior to the individual's 22nd birthday, is expected to continue indefinitely, and results in substantial limitation of three or more areas of major life activity (self-care, language, learning, mobility, self-direction, independent living)). The originally covered services were (i) in-home residential support; (ii) day support; (iii) prevocational services; (iv) supported employment services; (v) therapeutic consultation; (vi) environmental modifications; (vii) skilled nursing; (viii) assistive technology; (ix) crisis stabilization; (x) personal care and respite (both agency directed and consumer directed); (xi) family/caregiver training; (xii) personal emergency response systems; and (xiii) companion services (both agency directed and consumer directed). In SFY 2015, this waiver served 913 individuals/families with expenditures of \$28,747,525. Acute care costs for these individuals totaled \$9,388,868.

Intellectual Disabilities (ID) Waiver: This waiver was originally developed in 1991 to serve the needs of individuals and their families, who are determined to require the level of care in an ICF/IID. Such individuals must have a diagnosis of intellectual disability or if younger than six years old, be at developmental risk of significant limitations in major life activities. The services covered in ID are (i) assistive technology; (ii) companion services (both agency-directed and consumer-directed); (iii) crisis stabilization; (iv) day support; (v) environmental modifications; (vi) personal assistance and respite (both agency-directed and consumer-directed); (vii) personal emergency response systems; (viii) prevocational services; (ix) residential support services; (x) services facilitation (only for consumer-directed services); (xi) skilled nursing services; (xii) supported employment; (xiii) therapeutic consultation; and (xiv) transition services. In SFY 2015, this waiver served 10,174 individuals/families with expenditures of \$693,861,042. Acute care costs for these individuals totaled \$138,928,215.

Day Support (DS) Waiver: This waiver was originally developed in 2005 to serve the needs of individuals, along with their families, who have intellectual disabilities and have been determined to require the level of care in an ICF/IID. This waiver was developed to address the overwhelming needs of this population of individuals in the Commonwealth, because the ID waiver operated at capacity and was not funded for the higher numbers of individuals who required the covered services. This waiver was intended to be temporary measure while the individuals on the waiting list waited for an opening in the ID waiver. The services covered in DS are (i) day support; (ii) prevocational services; and (iii) supported employment. In SFY 2015, this waiver served 271 individuals/families with expenditures of \$3,806,006. Acute care costs for these individuals totaled \$3,103,295.

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Issues:

The Commonwealth's three waivers have not been substantially updated in recent years. DMAS and DBHDS have undertaken this waiver redesign in consideration of recent federal policy changes to ensure that Virginia's system of services and supports fully embraces community inclusion and full access for individuals who have disabilities. This redesign effort is important to (i) provide community-based services for individuals with significant medical and behavioral support needs; (ii) expand opportunities that promote smaller, more integrated independent living options with needed supports; (iii) enable providers to adapt their service provision and business model to support the values and expectations of the federally required community integration mandate; and (iv) comply with Settlement Agreement elements requiring expansion of integrated residential/day services and employment options for persons with intellectual/developmental disabilities.

In Virginia, funding and payment for services are broadly related to individual support needs. DMAS has found that differing expenditures have become associated with people who have similar needs. Currently, an individual's level of need for resources and supports is often not correlated to waiver expenditures. Over time, DMAS and DBHDS expect that better correlating individuals' support levels with the costs of their needs will enable the Commonwealth to more precisely predict costs, thereby leading to improved budgeting, which is expected to enable serving more individuals within current appropriations.

Recommendations:

DMAS and DBHDS recommend amending three existing waivers into three distinct waivers that will support all individuals who are eligible and have developmental disabilities by (i) integrating individuals with developmental disabilities into their communities by providing needed supports and resources; (ii) standardizing and simplifying access to services; (iii) offering services that promote community integration and engagement; (iv) improving providers' capacities and quality by increasing reimbursements as quality improves; (v) aligning this waiver redesign with recent research about supporting such individuals in smaller communities in order to achieve better outcomes; and (vi) creating a single, statewide waiting list that DBHDS will maintain to replace current waiting lists. Individuals will be ranked by priority based on the degree of jeopardy to their health and safety due to their unpaid caregivers' circumstances. Individuals and family/caregivers will have appeal rights for the priority assignment process but not the actual slot allocation determination.

DMAS and DBHDS believe that these recommendations will enable the Commonwealth to meet its obligations under the community integration mandate of the ADA, the

Supreme Court's *Olmstead Decision*, and the 2012 Settlement Agreement with the U.S. Department of Justice.

Family and Individual Supports (FIS) Waiver (formerly the DD Waiver): This new waiver will continue to support individuals with disabilities who are living with their families, friends or in their own residences. It will support individuals who have some medical or behavioral needs and will be open to children and adults. The following services will be added: (i) shared living; (ii) supported living residential; (iii) community coaching; (iv) community engagement; (v) workplace assistance services; (vi) private duty nursing; (vii) crisis support services; (viii) community-based crisis supports; (ix) center-based crisis supports; and (x) electronic home based supports.

Community Living Waiver (formerly the ID Waiver): This new waiver will remain a comprehensive waiver that includes 24/7 residential support services for those who require this level of support. It will be open to children and adults with developmental disabilities who may require intense medical supports, behavioral supports, or both. The following services will be added: (i) crisis support services; (ii) supported living residential; (iii) shared living; (iv) electronic home based support; (v) community engagement; (vi) community coaching; (vii) community guide (peer mentoring); (viii) community-based and center-based crisis supports; (ix) individual and family/caregiver training; (x) private duty nursing; and (xi) workplace assistance services.

Building Independence Waiver (formerly DS Waiver): This new waiver will support adults (18 years of age and older) who are able to live in their communities and control their own living arrangements with minimal supports. The following services will be added: (i) assistive technology; (ii) community-based and center-based crisis supports; (iii) environmental modifications; (iv) Personal Emergency Response Systems and electronic home based supports; (v) transition services; (vi) shared living; (vii) independent living supports; and (viii) community engagement/coaching (peer mentoring) services.

Currently provided prevocational services (defined as preparing an individual for paid/unpaid employment such as accepting supervision, attendance, task completion, problem solving, and safety) are recommended for discontinuation as part of this redesign action.

12VAC30-50-440. ~~Case management services for individuals with mental retardation.~~ (Repealed.)

~~A. Target Group. Medicaid eligible individuals who are mentally retarded as defined in state law.~~

~~1. An active client for mental retardation case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face to face contact every 90 days.~~

Billing can be submitted for an active client only for months in which direct or client related contacts, activity or communications occur.

2. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two predischARGE periods in twelve months.

B. Services will be provided in the entire State.

C. Comparability of Services: Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of Services. Mental retardation services to be provided include:

1. Assessment and planning services, to include developing a Consumer Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);
2. Linking the individual to services and supports specified in the consumer service plan;
3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;
4. Coordinating services and service planning with other agencies and providers involved with the individual;
5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and recreational services;
6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;
7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and
8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers:

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and serious/chronic mental illness to the Community Services Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the

provider of the services must meet certain criteria. These criteria shall be:

- a. The provider must guarantee that clients have access to emergency services on a 24 hour basis;
- b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;
- c. The provider must have the administrative and financial management capacity to meet state and federal requirements;
- d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;
- e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and
- f. The provider must be certified as a mental retardation case management agency by the DMHMRSAS.

3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager must possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

- (1) The definition, causes and program philosophy of mental retardation
- (2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination
- (3) Different types of assessments and their uses in program planning
- (4) Consumers' rights
- (5) Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures and generic community resources
- (6) Types of mental retardation programs and services
- (7) Effective oral, written and interpersonal communication principles and techniques
- (8) General principles of record documentation
- (9) The service planning process and the major components of a service plan

b. Skills in:

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- ~~(1) Interviewing~~
- ~~(2) Negotiating with consumers and service providers~~
- ~~(3) Observing, recording and reporting behaviors~~
- ~~(4) Identifying and documenting a consumer's needs for resources, services and other assistance~~
- ~~(5) Identifying services within the established service system to meet the consumer's needs~~
- ~~(6) Coordinating the provision of services by diverse public and private providers~~
- ~~(7) Using information from assessments, evaluations, observation and interviews to develop service plans~~
- ~~(8) Formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation;~~
- ~~(9) Using assessment tools~~
- ~~(10) Identifying community resources and organizations and coordinating resources and activities~~

~~e. Abilities to:~~

- ~~(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of people with mental retardation, respecting consumers' and families' privacy, believing consumers can grow)~~
- ~~(2) Be persistent and remain objective~~
- ~~(3) Work as team member, maintaining effective inter- and intra-agency working relationships~~
- ~~(4) Work independently, performing position duties under general supervision~~
- ~~(5) Communicate effectively, verbally and in writing~~
- ~~(6) Establish and maintain ongoing supportive relationships~~

~~F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.~~

- ~~1. Eligible recipients will have free choice of the providers of case management services.~~
- ~~2. Eligible recipients will have free choice of the providers of other medical care under the plan.~~

~~G. Payments for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.~~

~~**12VAC30-50-450. Case management services for individuals with mental retardation and related conditions who are participants in the Home and Community Based Care waivers for such individuals. (Repealed.)**~~

~~A. Target group: Medicaid eligible individuals with mental retardation and related conditions, or a child under 6 years of age who is at developmental risk, who have been determined~~

~~to be eligible for Home and Community Based Care Waiver Services for persons with mental retardation and related conditions:~~

~~1. An active client for waiver case management shall mean an individual who receives at least one face to face contact every 90 days and monthly on going case management interactions. There shall be no maximum service limits for case management services. Case management services may be initiated up to 3 months prior to the start of waiver services, unless the individual is institutionalized.~~

~~2. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two predischARGE periods in twelve months.~~

~~B. Services will be provided in entire State.~~

~~C. Comparability of Services. Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.~~

~~D. Definition of Services. Mental retardation case management services to be provided include:~~

- ~~1. Assessment and planning services, to include developing a Consumer Service Plan (does not include performing medical and psychiatric assessment but does not include referral for such assessment);~~
- ~~2. Linking the individual to services and supports specified in the consumer service plan;~~
- ~~3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;~~
- ~~4. Coordinating services with other agencies and providers involved with the individual;~~
- ~~5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and recreational services;~~
- ~~6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment; and~~
- ~~7. Following up and monitoring to assess ongoing progress and ensuring services are delivered; and~~
- ~~8. Education and counseling which guides the client and develop a supportive relationship that promotes the service plan.~~

~~E. Qualifications of Providers:~~

- ~~1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to~~

limit case management providers for individuals with mental retardation and serious/chronic mental illness to the Community Services Boards only to enable them to provide services to seriously or chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the provider of the services must meet certain criteria. These criteria shall be:

- a. The provider must guarantee that clients have access to emergency services on a 24 hour basis;
- b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individuals' ability to pay or eligibility for Medicaid reimbursement;
- c. The provider must have the administrative and financial management capacity to meet state and federal requirements;
- d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;
- e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and
- f. The provider must be certified as a mental retardation case management agency by the DMHMRSAS.

3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager must possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities, at the entry level. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation):

- a. Knowledge of:
 - (1) The definition, causes and program philosophy of mental retardation
 - (2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;
 - (3) Different types of assessments and their uses in program planning
 - (4) Consumers' rights
 - (5) Local service delivery systems, including support services
 - (6) Types of mental retardation programs and services

- (7) Effective oral, written and interpersonal communication principles and techniques
- (8) General principles of record documentation
- (9) The service planning process and the major components of a service plan

b. Skills in:

- (1) Interviewing
- (2) Negotiating with consumers and service providers
- (3) Observing, records and reporting behaviors
- (4) Identifying and documenting a consumer's needs for resources, services and other assistance
- (5) Identifying services within the established service system to meet the consumer's needs
- (6) Coordinating the provision of services by diverse public and private providers
- (7) Analyzing and planning for the service needs of mentally retarded persons
- (8) Formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation
- (9) Using assessment tools.

e. Abilities to:

- (1) Demonstrate a positive regard for consumers and their families (e.g., treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally retarded people, respecting consumers' and families' privacy, believing consumers can grow)
- (2) Be persistent and remain objective
- (3) Work as team member, maintaining effective inter- and intra-agency working relationships
- (4) Work independently, performing positive duties under general supervision
- (5) Communicate effectively, verbally and in writing
- (6) Establish and maintain ongoing supportive relationships.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

- 1. Eligible recipients will have free choice of the providers of case management services.
- 2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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12VAC30-50-455. Support coordination/case management for individuals with developmental disabilities (DD).

A. Target group. Individuals who have a developmental disability as defined in § 37.2-100 of the Code of Virginia shall be eligible for support coordination/case management.

1. An individual receiving DD support coordination/case management shall mean an individual for whom there is an individual support plan (ISP) in effect that requires monthly direct or in-person contact, communication, or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the support coordinator/case manager every 90 days. Billing shall be submitted for an individual only for months in which direct or in-person contact, activity, or communication occurs and the support coordinator's/case manager's records document the billed activity. Service providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

2. Individuals who have developmental disabilities as defined in state law but who are on the DD waiting list for waiver services may receive support coordination/case management services.

B. Services shall be provided in the entire Commonwealth.

C. Comparability of services. Services shall not be comparable in amount, duration, and scope. The authority of § 1915(g)(1) of the Social Security Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) and (C) of the Social Security Act.

D. Definition of services.

1. Developmental disability support coordination/case management services to be provided shall include:

a. Assessing and planning services, to include developing an ISP, which does not include performing medical and psychiatric assessment but does include referral for such assessments;

b. Connecting, joining, arranging, or associating the individual to or for services and supports specified in the ISP;

c. Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources;

d. Coordinating services and service planning with other agencies and service providers involved with the individual;

e. Enhancing community integration by contacting other entities to arrange community access and involvement;

f. Making collateral contacts with the individual to promote implementation of the ISP and successful community adjustment;

g. Following and monitoring the individual to assess ongoing progress and ensuring services are delivered; and

h. Educating and counseling that guides the individual and develops a supportive relationship that promotes the ISP.

2. There shall be no maximum service limits for support coordination/case management services except for individuals residing in institutions or medical facilities. For these individuals, reimbursement for support coordination/case management shall be limited to 90 days pre-discharge (immediately preceding discharge) from the institution into the community. While individuals may require re-entry to institutions or medical facilities for emergencies, discharge planning efforts should be significant to prevent readmission. For this reason, support coordination/case management may be billed for only two 90-day pre-discharge periods in a 12-month period.

E. Qualifications of providers.

1. Services shall not be comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Social Security Act is hereby invoked to limit support coordination/case management providers to the community services boards/behavioral health authorities (CSBs/BHAs). CSBs/BHAs shall contract with private support coordinators/case managers for this service. CSBs/BHAs shall have current, signed provider agreements with DMAS and shall directly bill DMAS for reimbursement.

2. DD support coordinators/case managers shall not be (i) the direct care staff person, (ii) the immediate supervisor of the direct care staff person, (iii) otherwise related by business or organization to the direct care staff person, or (iv) an immediate family member of the direct care staff person.

3. Parents, spouses, or any family living with the individual may not provide direct support coordination/case management services for the individual or spouse of the individual with whom they live or be employed by a company that provides support coordination/case management for the individual, spouse, or individual with whom they live.

4. Providers of DD support coordination/case management services shall meet the following criteria:

a. The provider shall guarantee that individuals have access to emergency services on a 24-hour basis;

b. The provider shall demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid;

c. The provider shall have the administrative and financial management capacity to meet state and federal requirements;

d. The provider shall have the ability to document and maintain individual case records in accordance with state and federal requirements; and

e. The provider shall be licensed as a developmental disability support coordination/case management entity contracted with the CSB.

5. Support coordinators/case managers who provide DD case management services after September 1, 2016, shall possess a minimum of an undergraduate degree in a human services field. Support coordinators/case managers who do not possess a minimum of an undergraduate degree in a human services field may continue to provide support coordination/case management if they are employed by an entity with a Medicaid participation agreement to provide DD case management prior to February 1, 2005, and maintain employment with the provider under that agreement without interruption.

6. In addition to the requirements in subdivision 5 of this subsection, the support coordinator/case manager shall possess developmental disability work experience or relevant education that indicates that the incumbent at entry level possesses the following knowledge, skills, and abilities that shall be documented in the employment application form or supporting documentation or during the job interview. The knowledge, skills, and abilities shall include:

a. Knowledge of:

(1) The definition, causes, and program philosophy of developmental disability;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

(3) Different types of assessments and their uses in program planning;

(4) Individual rights;

(5) Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures, and generic community resources;

(6) Types of developmental disability programs and services;

(7) Effective oral, written, and interpersonal communication principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and the major components of an individual support plan.

b. Skills in:

(1) Interviewing;

(2) Negotiating with individual consumers and service providers;

(3) Observing, recording, and reporting behaviors;

(4) Identifying and documenting an individual consumer's needs for resources, services, and other assistance;

(5) Identifying services to meet the individual's needs;

(6) Coordinating the provision of services by diverse public and private providers;

(7) Analyzing and planning for the service needs of individuals with developmental disabilities;

(8) Formulating, writing, and implementing individual support plans to promote goal attainment for individuals with developmental disabilities;

(9) Successfully using assessment tools; and

(10) Identifying community resources and organizations and coordinating resources and activities.

c. Ability to:

(1) Demonstrate a positive regard for individuals and their families (e.g., permitting risk taking, avoiding stereotypes of individuals with developmental disabilities, respecting individuals' and families' privacy, believing individuals can grow);

(2) Be persistent and remain objective;

(3) Work as team member, maintaining effective interagency and intra-agency working relationships;

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

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

(6) Establish and maintain ongoing supportive relationships.

7. Support coordinators/case managers who are employed by an organization contracted with the CSB/BHA shall receive supervision within the employing organization. The supervisor of the support coordinator/case manager shall have at least a master's level degree in a human services field or have five years of experience in the field working with individuals with developmental disability as defined in § 37.2-100 of the Code of Virginia, or both.

8. Support coordinators/case managers who are contracted with the CSB/BHA shall obtain one hour of documented supervision by the CSB every three months.

9. A support coordinator/case manager shall complete a minimum of eight hours of training annually in one or a combination of the areas described in the knowledge, skills, and abilities in subdivision 6 of this subsection and shall provide documentation to demonstrate that training is completed to his supervisor. The documentation shall be maintained by the supervisor of the support

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coordinator/case manager for the purposes of utilization review.

F. The state assures that the provision of support coordination/case management services shall not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Social Security Act.

1. To provide choice to individuals enrolled in the Building Independence (BI), Community Living (CL), and Family And Individual Supports (FIS) waivers, CSB/BHAs shall contract with private support coordination/case management entities to provide DD support coordination/case management, except if there are no qualified providers in that CSB/BHA's catchment area, then the CSB/BHA shall provide services. CSBs/BHAs shall be the only licensed entities permitted to provide DD support coordination/case management.

2. Individuals who are eligible for the BI, CL, and FIS waivers shall have free choice of the providers of support coordination/case management services within the parameters described in subdivision 1 of this subsection and as follows:

a. For those individuals that receive intellectual disability (ID) case management services:

(1) The CSB that serves the individual will be the provider of support coordination/case management.

(2) The CSB shall provide a choice of support coordinator/case managers within the CSB.

(3) If the individual or family decides that no choice is desired in that CSB, the CSB shall afford a choice of another CSB with whom the responsible CSB has a memorandum of agreement.

(4) At any time, an individual may make a request to change his support coordinator/case manager.

b. For those individuals who receive DD case management services:

(1) The CSB that serves the individual will be the provider of support coordination/case management.

(2) The CSB shall provide a choice of support coordinator/case managers within the CSB.

(3) If the individual or family decides that no choice is desired in that CSB, the CSB shall afford a choice of another CSB with whom the responsible CSB has a memorandum of agreement.

(4) If the individual or family decides not to choose the responsible CSB or the CSB with whom there is a memorandum of agreement, then the individual or family will be given a choice of a private provider with whom the responsible CSB has a contract for support coordination/case management.

(5) At any time, an individual may make a request to change their support coordinator/case manager.

3. Individuals who are eligible for the BI, CL, and FIS waivers shall have free choice of the providers of other medical care under the plan.

4. When the required support coordination/case management services are contracted out to a private entity, the CSB/BHA shall remain the responsible provider and only the CSB/BHA may bill DMAS for Medicaid reimbursement.

G. Payments for support coordination/case management services under the individual support plan (ISP) shall not duplicate payments made to public agencies or private entities under other program authorities for this same or similar purpose.

H. The support coordinator/case manager shall maintain the following documentation, in either hard copy or electronic format, for a period of not less than six years from each individual's last date of service or in the case of a minor child, six years after the minor child's 18th birthday:

1. All assessments and reassessments completed for the individual, all ISPs for the individual, and every service providers' plan for supports completed for the individual;

2. All supporting documentation related to any change in the ISP;

3. All related communication (including dates) with the individual, family/caregiver, consultants, providers, Department of Behavioral Health and Developmental Services, Department of Medical Assistance Services, Department of Social Services, Department for Aging and Rehabilitative Services, or other related parties;

4. An ongoing log that documents all contacts (including dates) made by the support coordinator/case manager related to the individual and family/caregiver; and

5. A copy of the current DMAS-225 form.

I. Individual choice of provider entities. The individual shall have the option of selecting the provider of his choice from among those providers meeting the individual's needs. The support coordinator/case manager shall inform the individual, and family member/caregiver as appropriate, of all available enrolled waiver service providers in the community in which he desires services, and he shall have the option of selecting the provider of his choice from the list of enrolled service providers.

J. Support coordinator/case manager's responsibility for the Medicaid Long Term Care Communication Form (DMAS-225). It shall be the responsibility of the support coordinator/case manager to notify Department of Medical Assistance Services, Department of Behavioral Health and Developmental Services, and Department of Social Services, in writing within five business days, when any of the following circumstances occur:

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

- ~~2. An individual dies.~~
- ~~3. An individual is discharged or terminated from waiver services.~~
- ~~4. Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 calendar days.~~
- ~~5. A selection by the individual or his family/caregiver, as appropriate, of a different support coordination/case management provider.~~

12VAC30-50-490. Case management for individuals with developmental disabilities, including autism. (Repealed.)

~~A. Target group. Medicaid eligible individuals with related conditions who are six years of age and older and who are on the waiting list or are receiving services under the Individual and Family Developmental Disabilities Support (IFDDS) Waiver.~~

~~1. An active client for case management shall mean an individual for whom there is a plan of care that requires regular direct or client related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face to face contact every 90 calendar days. Billing can be submitted for an active client only for months in which direct or client related contacts, activity or communications occur.~~

~~2. When an individual applies for the IFDDS Waiver and there is no available funding (slots), he will be placed on a waitlist until funding is available. The "Initial Waitlist Plan of Care" is completed with the case manager and identifies the services anticipated once a slot is available. Individuals on the waitlist do not have routine case management services unless there is a documented special service need in the plan of care. Case managers may make face to face contact every 90 calendar days to monitor the special service need and documentation is required to support such contact. The case manager will assure the plan of care addresses the current needs of the individual and will coordinate with DMAS to assure actual enrollment into the waiver upon slot availability.~~

~~3. The unit of service is one month. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management for institutionalized individuals may be billed for no more than two months in a 12 month cycle.~~

~~4. The unit of service is one month. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management for institutionalized individuals may be billed for no more than two months in a 12 month cycle.~~

~~B. Services will be provided in the entire state.~~

~~C. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Social Security Act (Act) is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.~~

~~D. Definition of services. Case management services will be provided for Medicaid eligible individuals with related conditions who are on the waiting list for or participants in the home and community based care IFDDS Waiver. Case management services to be provided include:~~

- ~~1. Assessment and planning services, to include developing a consumer service plan (does not include performing medical and psychiatric assessment but does include referral for such assessments);~~
- ~~2. Linking the individual to services and supports specified in the consumer service plan;~~
- ~~3. Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources;~~
- ~~4. Coordinating services with other agencies and providers involved with the individual;~~
- ~~5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills and use vocational, civic, and recreational services;~~
- ~~6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;~~
- ~~7. Following up and monitoring to assess ongoing progress and ensure services are delivered;~~
- ~~8. Education and counseling that guides the individual and develops a supportive relationship that promotes the service plan; and~~
- ~~9. Benefits counseling.~~

~~E. Qualifications of providers. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, specific provider qualifications are:~~

- ~~1. To qualify as a provider of services through DMAS for IFDDS Waiver case management, the service provider must meet these criteria:

 - ~~a. Have the administrative and financial management capacity to meet state and federal requirements;~~
 - ~~b. Have the ability to document and maintain recipient case records in accordance with state and federal requirements; and~~
 - ~~c. Be enrolled as an IFDDS case management agency by DMAS.~~~~
- ~~2. Providers may bill for Medicaid case management only when the services are provided by qualified case managers.~~

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The case manager must possess a combination of developmental disability work experience or relevant education, which indicates that the individual possesses the following knowledge, skills, and abilities, at the entry level. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

- (1) The definition, causes, and program philosophy of developmental disabilities;
- (2) Treatment modalities and intervention techniques, such as behavior management, independent living skills, training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;
- (3) Different types of assessments and their uses in program planning;
- (4) Individuals' rights;
- (5) Local service delivery systems, including support services;
- (6) Types of developmental disability programs and services;
- (7) Effective oral, written, and interpersonal communication principles and techniques;
- (8) General principles of record documentation; and
- (9) The service planning process and the major components of a service plan.

b. Skills in:

- (1) Interviewing;
- (2) Negotiating with individuals and service providers;
- (3) Observing, recording, and reporting behaviors;
- (4) Identifying and documenting an individual's needs for resources, services, and other assistance;
- (5) Identifying services within the established service system to meet the individual's needs;
- (6) Coordinating the provision of services by diverse public and private providers;
- (7) Analyzing and planning for the service needs of developmentally disabled persons;
- (8) Formulating, writing, and implementing individual-specific service plans to promote goal attainment for recipients with developmental disabilities; and
- (9) Using assessment tools.

c. Abilities to:

- (1) Demonstrate a positive regard for individuals and their families (e.g., allowing risk taking, avoiding stereotypes of developmentally disabled people, respecting individuals' and families' privacy, believing individuals can grow);
- (2) Be persistent and remain objective;

- (3) Work as a team member, maintaining effective inter- and intra-agency working relationships;
- (4) Work independently, performing positive duties under general supervision;
- (5) Communicate effectively, orally and in writing; and
- (6) Establish and maintain ongoing supportive relationships.

3. In addition, case managers who enroll with DMAS to provide case management services after (insert the effective date of these regulations) must possess a minimum of an undergraduate degree in a human services field. Providers who had a Medicaid participation agreement to provide case management prior to February 1, 2005, and who maintain that agreement without interruption may continue to provide case management using the KSA requirements effective prior to February 1, 2005.

4. Case managers who are employed by an organization must receive supervision within the same organization. Case managers who are self-employed must obtain one hour of documented supervision every three months when the case manager has active cases. The individual who provides the supervision to the case manager must have a master's level degree in a human services field and/or have five years of satisfactory experience in the field working with individuals with related conditions as defined in 42 CFR 435.1009. A case management provider cannot supervise another case management provider.

5. Case managers must complete eight hours of training annually in one or a combination of the areas described in the knowledge, skills and abilities (KSA) subdivision. Case managers must have documentation to demonstrate training is completed. The documentation must be maintained by the case manager for the purposes of utilization review.

6. Parents, spouses, or any person living with the individual may not provide direct case management services for their child, spouse or the individual with whom they live or be employed by a company that provides case management for their child, spouse, or the individual with whom they live.

7. A case manager may provide services facilitation services. In these cases, the case manager must meet all the case management provider requirements as well as the service facilitation provider requirements. Individuals and their family/caregivers, as appropriate, have the right to choose whether the case manager may provide services facilitation or to have a separate services facilitator and this choice must be clearly documented in the individual's record. If case managers are not services facilitation providers, the case manager must assist the individual and his family/caregiver, as appropriate, to locate an available services facilitator.

8. If the case manager is not serving as the individual's services facilitator, the case manager may conduct the assessments and reassessment for CD services if the individual or his family/caregiver, as appropriate, chooses. The individual's choice must be clearly documented in the case management record along with which provider is responsible for conducting the assessments and reassessments required for CD services.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

12VAC30-60-360. Criteria for care in facilities for mentally retarded persons individuals with developmental disabilities including intellectual disabilities.

§ 4.0 A. Definitions. The following words and terms, when used in these criteria this section, shall have the following meaning meanings, unless the context clearly indicated indicates otherwise:

- "Active treatment" means the same as 42 CFR 483.440(a).
- "no assistance" shall mean "No assistance" means no help is needed.
- "Often" means that a behavior occurs two to three times per month.
- ~~"prompting/structuring" shall mean~~ "Prompting/structuring" means that an individual requires, prior to the functioning, some verbal direction and/or or some rearrangement, or both, of the environment is needed.
- "Rarely" means that a behavior occurs once a quarter or less frequently.
- "Regularly" means that a behavior occurs once a week or more frequently.
- "Some direct assistance" means that an individual requires a helper to be present and provide some physical guidance/support (with or without verbal direction).
- "Sometimes" means that a behavior occurs once a month or less frequently.
- "Supervision" means that an individual requires a helper to be present during the function and provide only verbal direction, general prompts, or guidance, or all of these.
- "supervision" shall mean that a helper must be present during the function and provide only verbal direction, general prompts, and/or guidance.

~~"some direct assistance" shall mean that helper must be present and provide some physical guidance/support (with or without verbal direction).~~

~~"total care" shall mean~~ "Total care" means that an individual requires a helper must to perform all or nearly all of the functions.

~~"rarely" shall mean that a behavior occurs quarterly or less.~~

~~"sometimes" shall mean that a behavior occurs once a month or less.~~

~~"often" shall mean that a behavior occurs 2-3 times a month.~~

~~"regularly" shall mean that a behavior occurs weekly or more.~~

§ 4.1 Utilization Control regulations require that criteria be formulated for guidance for appropriate levels of services. Traditionally, care for the mentally retarded has been institutionally based; however, this level of care need not be confined to a specific setting. The habilitative and health needs of the client are the determining issues.

§ 4.2 The purpose of these regulations is to establish B. This section establishes standard criteria to measure eligibility for Medicaid payment for an individual to receive care in facilities. Medicaid ~~can pay for~~ covers care only when the client individual is receiving appropriate services and when "active treatment" is being provided. An individual's need for care ~~must shall~~ meet these the level of functioning criteria in the VIDES form, referenced in 12VAC30-120-535, before any authorization for payment by Medicaid will be made for ~~either institutional or waived rehabilitative services for the mentally retarded.~~

§ 4.3 C. Care in facilities for ~~the mentally retarded individuals with developmental or intellectual disabilities~~ requires planned programs ~~for of~~ services to address habilitative needs ~~and/or or~~ health needs, or both, related services which that exceed the level of room, board, and general supervision of daily activities.

1. Such ~~eases shall~~ care may be a combination of habilitative, rehabilitative, and health services directed toward increasing the functional capacity of the ~~retarded person individual.~~ Examples of services such care shall include (i) training in the activities of daily living, (ii) training in task-learning skills, (iii) learning socially acceptable behaviors, (iv) basic community living programming, or (v) health care and health maintenance.

2. The overall objective of programming shall be the attainment of the optimal physical, intellectual, social, or task learning level ~~which that~~ the person individual can presently or potentially achieve.

§ 4.4 D. The evaluation and re-evaluation for determination of the intermediate care facility (ICF) level of care in a facility for ~~the mentally retarded individuals with development/intellectual disabilities~~ shall be based on (i) the needs of the ~~person individual,~~ (ii) the reasonable expectations of the ~~resident's~~ individual's capabilities, (iii) the

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appropriateness of programming, ~~whether~~ (iv) the progress is demonstrated from the training, and, (v) in an institution, whether the services could reasonably be provided in a less restrictive environment.

~~§ 4.5 Patient~~ E. Individual assessment criteria. The ~~patient~~ individual assessment criteria ~~are divided into broad categories of needs, or services provided. These must shall~~ be evaluated in detail to determine the ~~abilities/skills which skills, abilities, and status that~~ will be the basis for the development of ~~a plan for care an individual support plan.~~ The evaluation process ~~will demonstrate shall~~ indicate a need for ~~programming an array of an individual support plan that addresses the individual's skills and, abilities, or need for health care services. These, which~~ have been organized in ~~the~~ seven major categories ~~set forth in subsection F of this section.~~ Level of functioning in each category is graded from the most dependent to the least dependent. In some categories, the dependency status is rated by the degree of assistance required. In other categories, the dependency is established by the frequency of a behavior or ~~the~~ ability to perform a given task.

~~§ 4.6 F. Dependency level.~~ The ~~resident must meet the indicated dependency level in TWO OR MORE of categories 1 through 7 individual shall demonstrate two or more of the skills or statuses listed in subdivisions 1 through 7 of this subsection. To demonstrate a skill or exhibit a status, the individual shall meet the dependency level described for that skill or status. The questions referenced in subdivisions 1 through 7 of this subsection to meet a dependency level are found in Table 1 of this subsection.~~

1. Health status. To meet this category:

- ~~1. a.~~ 1. a. Two or more questions must be answered with a 4, ~~OR~~ OR or
- ~~2. b.~~ 2. b. Question "j" must be answered "yes."

~~B. 2. Communication Skills— skills.~~ 2. Communication skills. To meet this category, three or more questions must be answered with a 3 or a 4.

~~C. 3. Task Learning Skills— learning skills.~~ 3. Task learning skills. To meet this category, three or more questions must be answered with a 3 or a 4.

~~D. 4. Personal Care— care skills.~~ 4. Personal care skills. To meet this category, either:

- ~~1. a.~~ 1. a. Question "a" must be answered with a 4 or a 5, ~~OR~~ OR
- ~~2. b.~~ 2. b. Question "b" must be answered with a 4 or a 5, ~~OR~~ OR
- ~~3. c.~~ 3. c. Questions "c" and "d" must be answered with a 4 or a 5.

~~E. Mobility— To~~ 5. Mobility status. To meet this category any one question must be answered with a 4 or a 5.

~~F. 6. Behavior— To~~ 6. Behavior status. To meet this category, any one question must be answered with a 3 or a 4.

~~G. 7. Community Living— To~~ living skills. To meet this category:

- ~~1. a.~~ 1. a. Any two of the questions "b", "e", or "g" must be answered with a 4 or a 5, ~~OR;~~ or
- ~~2. b.~~ 2. b. Three or more questions must be answered with a 4 or a 5.

§ 4.7. Level of functioning survey.

<u>A. HEALTH STATUS Table 1 – Level of Functioning Survey</u>				
<u>1. Health status:</u> How often is nursing care or nursing supervision by a licensed nurse required for the following? (Key: 1=rarely, 2=sometimes, 3=often, and 4=regularly)				
1. a. <u>1. a.</u> Medication administration and/or or evaluation for effectiveness of a medication regimen?	1	2	3	4
2. b. <u>2. b.</u> Direct services: i.e., care for lesions, dressings, or treatments, (other than shampoos, foot power powder, etc.)	1	2	3	4
3. c. <u>3. c.</u> Seizures control	1	2	3	4
4. d. <u>4. d.</u> Teaching diagnosed disease control and care, including for diabetes	1	2	3	4
5. e. <u>5. e.</u> Management of care of diagnosed circulatory or respiratory problems	1	2	3	4
6. f. <u>6. f.</u> Motor disabilities which that interfere with all activities of Daily Living— Bathing, Dressing, Mobility, Toileting etc., <u>daily living (i.e. bathing, dressing, mobility, toileting, etc.)</u>	1	2	3	4
7. g. <u>7. g.</u> Observation for choking/aspiration <u>choking or aspiration</u> while eating, or drinking?	1	2	3	4
8. h. <u>8. h.</u> Supervision of use of adaptive equipment, (i.e., special spoon, braces, etc.)	1	2	3	4
9. i. <u>9. i.</u> Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)	1	2	3	4

10. <u>j.</u> Is age 55 or older, has a diagnosis of a chronic disease, and has been in an institution 20 years or more	1	2	3	4	8. <u>h.</u> Name people or objects when describing pictures? <u>pictures.</u>	1	2	3	4	
B. COMMUNICATION					9. <u>i.</u> Discriminate between one, many, lot? and a lot.	1	2	3	4	
Using the 2. Communication skills: How often does this person: Key 1=regularly, 2=often, 3=sometimes, 4=rarely; how often does this person					D. PERSONAL and SELF CARE					
1. <u>a.</u> Indicate wants by pointing, vocal noises, or signs?	1	2	3	4	4. Personal and self care: With what type of assistance can this person currently (Key: 1=No Assistance 1=no assistance, 2=Prompting/Structures 2=prompting/structures, 3=Supervision 3=supervision, 4=Some Direct Assistance 4=some direct assistance, 5=Total Care) 5=total care)					
2. <u>b.</u> Use simple words, phrases, short sentences?	1	2	3	4	1. <u>a.</u> Perform toileting functions: (i.e., maintain bladder and bowel continence, clean self, etc.)?	1	2	3	4	5
3. <u>c.</u> Ask for at least ten 10 things using appropriate names?	1	2	3	4	2. <u>b.</u> Perform eating/feeding eating or feeding functions: (i.e., drinks liquids and eats with spoon or fork, etc.)?	1	2	3	4	5
4. <u>d.</u> Understand simple words, phrases or instructions containing prepositions: i.e., on, in, behind?	1	2	3	4	3. <u>c.</u> Perform bathing function: (i.e., bathes, runs bath, dry dries self, etc.)?	1	2	3	4	5
5. <u>e.</u> Speak in an easily understood manner?	1	2	3	4	4. <u>d.</u> Dress self himself completely; (i.e., including fastening, putting on clothes, etc.)?	1	2	3	4	5
6. <u>f.</u> Identify self, place of residence, and significant others?	1	2	3	4	E. MOBILITY					
C. TASK LEARNING SKILLS					5. Mobility: With what type of assistance can this person currently (Key: 1=No Assistance 1=no assistance, 2=Prompting/Structures 2=prompting/structures, 3=Supervision 3=supervision, 4=Some Direct Assistance 4=some direct assistance, 5=Total Care) 5=total care)					
3. Task learning skills: How often does this person perform the following activities? (Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)					1. <u>a.</u> Move, (i.e., walking, wheeling) around his environment?	1	2	3	4	5
1. <u>a.</u> Pay attention to purposeful activities for 5 five minutes?	1	2	3	4	2. <u>b.</u> Rise from lying down to sitting positions or sits without support?	1	2	3	4	5
2. <u>b.</u> Stay with a 3-step three-step task for more than 15 minutes?	1	2	3	4	3. <u>c.</u> Turn and position himself in bed; or roll over?	1	2	3	4	5
3. <u>c.</u> Tell time to the hour and understand time intervals?	1	2	3	4						
4. <u>d.</u> Count more than 10 objects? <u>objects.</u>	1	2	3	4						
5. <u>e.</u> Do simple addition, subtraction? <u>subtraction.</u>	1	2	3	4						
6. <u>f.</u> Write or print ten words? 10 words.	1	2	3	4						
7. <u>g.</u> Discriminate shapes, sizes, or colors? colors.	1	2	3	4						

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F. BEHAVIOR					
6. Behavior: How often does this person (Key: 1=Rarely 1=rarely, 2=Sometimes 2=sometimes, 3=Often 3=often, and 4=Regularly 4=regularly)					
1. a. Engage in self destructive behavior?	1	2	3	4	
2. b. Threaten or do physical violence to others?	1	2	3	4	
3. c. Throw things, damage property, have temper outbursts?	1	2	3	4	
4. d. Respond to others in a socially unacceptable manner - (without undue anger, frustration, or hostility)?	1	2	3	4	
G. COMMUNITY LIVING SKILLS					
7. Community Living Skills: With what type of assistance can this person currently: (Key: 1=No Assistance 1=no assistance, 2=Prompting/Structures 2=prompting/structures, 3=Supervision 3=supervision, 4=Some Direct Assistance 4=some direct assistance, 5=Total Care 5=total care)					
1. a. Prepare simple foods requiring no mixing or cooking?	1	2	3	4	5
2. b. Take care of personal belongings, and room (excluding vacuuming, ironing, clothes washing/drying washing and drying, wet mopping)?	1	2	3	4	5
3. c. Add coins of various denominations up to one dollar?	1	2	3	4	5
4. d. Use the telephone to call home, doctor, fire, and police?	1	2	3	4	5
5. e. Recognize survival signs/words signs and words: (i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.)?	1	2	3	4	5
6. f. Refrain from exhibiting unacceptable sexual behavior in public?	1	2	3	4	5

7. g. Go around cottage, ward, or building, without running away, wandering off, or becoming lost?	1	2	3	4	5
8. h. Make minor purchases, (i.e., candy, soft drink, etc)?	1	2	3	4	5

12VAC30-80-110. Fee-for-service: case management.

~~A. Targeted case management for high risk pregnant women and infants up to two years of age, for community mental health and intellectual disability services, and for individuals who have applied for or are participating in the Individual and Family Developmental Disability Support Waiver program (IFDDS Waiver) shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.~~

~~B. A. Targeted case management for early intervention (Part C) children.~~

1. Targeted case management for children from birth to three years of age who have developmental delay and who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is ~~monthly~~ one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates are effective for services on or after October 11, 2011. Rates are published on the agency's website at www.dmas.virginia.gov.

~~2. Case management shall not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services and intensive in-home services for children and adolescents.~~

~~3. 2.~~ Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12VAC30-50-410. Providers of early intervention case management shall coordinate services with providers of case management services for high risk infants, pursuant to 12VAC30-50-410, to ensure that services are not duplicated.

4. ~~3.~~ Each entity receiving payment for services as defined in 12VAC30-50-415 shall be required to furnish the following to DMAS, upon request:

- a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and
- b. Cost information used by practitioner.

~~5. 4.~~ Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of targeted case management through post-payment review (PPR). PPRs ensure that paid services were (i) rendered appropriately, in accordance with state

and federal laws, regulations, policies, and program requirements, (ii) provided in a timely manner, and (iii) paid correctly.

B. Reimbursement for targeted case management for high risk pregnant women and infants and children.

1. Targeted case management for high risk pregnant women and infants up to two years of age defined in 12VAC30-50-410 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is one day. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of September 10, 2013, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management service under this subsection except for case management for early intervention provided under 12VAC30-50-415. Providers of case management for high risk pregnant women and infants and children shall coordinate services with providers of early intervention case management to ensure that services are not duplicated.

4. Each provider receiving payment for the service under this subsection will be required to furnish the following to the Medicaid agency, upon request:

a. Data on the hourly utilization of this service furnished to Medicaid members; and

b. Cost information used by practitioners furnishing this service.

5. Rate updates will be based on utilization and cost information obtained from the providers.

C. Reimbursement for targeted case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance.

1. Targeted case management services for seriously mentally ill adults and emotionally disturbed children defined in 12VAC30-50-420 or for youth at risk of serious emotional disturbance defined in 12VAC30-50-430 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of September 10, 2013, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of

serious emotional disturbance may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management services under this subsection.

4. Each provider receiving payment for the services under this subsection will be required to furnish the following to the Medicaid agency, upon request:

a. Data on the hourly utilization of these services furnished to Medicaid members; and

b. Cost information used by the practitioner furnishing these services.

5. Rate updates will be based on utilization and cost information obtained from the providers.

D. Reimbursement for targeted case management for individuals with intellectual disability or developmental disability.

1. Targeted case management for individuals with intellectual disability defined in 12VAC30-50-440 and individuals with developmental disabilities defined in 12VAC30-50-450 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (the charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2016, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov

2. Case management for individuals with intellectual disability or developmental disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management service under this subsection.

4. Each provider receiving payment for the service under this subsection will be required to furnish the following to the Medicaid agency, upon request:

a. Data on the hourly utilization of this service furnished to Medicaid members; and

b. Cost information by practitioners furnishing this service.

5. Rate updates will be based on utilization and cost information obtained from the providers.

12VAC30-120-501. Definitions.

The following words and terms used in 12VAC30-120-501 et seq. shall have the following meanings unless the context clearly indicates otherwise:

"Applicant" means an individual (or his representative acting on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to a DD waiver.

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"BI" means the Building Independence Waiver as set out in 12VAC30-120-1500 et seq.

"CL" means the Community Living Waiver as set out in 12VAC30-120-1000 et seq.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care information by the support coordinator/case manager and is used as a basis for the development of the Individual Support Plan.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DD waivers" means the FIS (12VAC30-12-700 et seq.), CL (12VAC30-120-1000 et seq.), and the BI (12VAC30-120-1500 et seq.) waivers in the collective.

"Developmental disability" or "DD" means the same as defined in § 37.2-100 of the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services.

"Enroll" with respect to an individual means (i) the local department of social services has determined the individual's financial eligibility for Medicaid as set out in 12VAC30-120-501 et seq., (ii) the individual has been determined by the support coordinator/case manager to meet the functional eligibility requirements in the VIDES form (referenced in 12VAC30-120-535) for the waiver, (iii) the Department of Behavioral Health and Developmental Services has verified the availability of a waiver slot for the individual, and (iv) the individual has agreed to accept the waiver slot.

"Family" means, for the purpose of receiving individual and family/caregiver training services, the unpaid people who live with or provide care to an individual served on the waiver and may include a parent, a spouse, children, relatives, a foster family, or in-laws but shall not include persons who are compensated, by any possible means, to care for the individual.

"FIS" means the Family and Individual Support Waiver as set out in 12VAC30-120-700 et seq.

"Health, safety, and welfare standard" means the same as defined in 12VAC30-120-1000.

"ICF/IID" means a facility or distinct part of a facility licensed by DBHDS and meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disabilities and individuals with related conditions and that addresses the total needs of the individuals, which include physical, intellectual, social, emotional, and habilitation, and provides active treatment as defined in 42 CFR 483.440.

"IDEA" means the Individuals with Disabilities Education Act (20 USC § 1400 et seq.).

"Individual" means the Commonwealth's citizen, including a child, who meets the income and resource standards in order to be eligible for Medicaid-covered services, has a diagnosis

of developmental disability, and is eligible for the BI, CL, or FIS Waiver. The individual may be a person on the DD waiting list or a person enrolled and receiving waiver services.

"Levels of support" means the level (1-7) to which an individual is assigned as a result of the utilization of the SIS[®] score and the Virginia Supplemental Questions. The level of support is derived from a calculation using the SIS[®] score and correlates to an individual's needs. The Virginia Supplemental Questions form is completed to gather additional information regarding the needs of an individual whose SIS[®] responses regarding medical or behavioral needs indicate a high level of support needs. For individuals in Levels 6 and 7, the Virginia Supplemental Questions may also be used to determine the level of support.

"Positive behavior support" means an applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to enhance the individual's quality of life and minimize his challenging behaviors.

"Risk assessment" means the same as defined in 12VAC30-120-1000.

"Slot" means an opening or vacancy in waiver services for an individual.

"Support coordination/case management" means the same as defined in 12VAC30-50-455 D.

"Support coordinator/case manager" means the person who provides support coordination/case management services to individuals enrolled in one of the DD waivers or are listed on the DD waivers waiting list in accordance with 12VAC30-50-455.

"Supporting documentation" means any written or electronic materials used to record and verify the individual's support needs, services provided, and contacts made on behalf of the individual and may include, but shall not be limited to, the personal profile, individual support plan, service providers' plans for supports, progress notes, reports, medical orders, contact logs, attendance logs, and assessments. Supporting documentation shall be maintained to support claims for all services submitted to DMAS for reimbursement.

"Support package" means a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs, and abilities.

"Supports Intensity Scale[®]" or "SIS[®]" means an assessment tool and form that is published by the American Association on Intellectual and Developmental Disabilities and administered through a thorough interview process that measures and documents an individual's practical support requirements in personal, school-related or work-related, social, behavioral, and medical areas in order to identify and determine the types and intensity levels of the supports required by that individual in order to live successfully in the community.

"Tiers of reimbursement" means tiers that are tied to an individual's level of support, so that providers are reimbursed for services provided to individuals consistent with that level of support.

"VDSS" means the Virginia Department of Social Services.

"Waiver Slot Assignment Committee" or "WSAC" means an impartial body of trained volunteers established for each locality or region with responsibility for recommending individuals eligible for a waiver slot according to their urgency of need. All WSACs will be composed of community members who will not be employees of a CSB or a private provider of either support coordination/case management or waiver services. WSAC members will be knowledgeable and have experience in the DD service system.

12VAC30-120-505. FIS, CL, and BI Waiver establishment, legal authority, description; waiver population, SIS[®] requirements.

A. Selected home and community-based waiver services shall be available through § 1915(c) waivers of the Social Security Act. The waivers shall be named (i) Family and Individual Supports (FIS), (ii) Community Living (CL), and (iii) Building Independence (BI) (collectively referred to as the Developmental Disabilities (DD) Waivers). Under the DD waivers, DMAS has waived § 1902(a) (10) (B) and (C) of the Social Security Act related to comparability of services. These services shall be required, appropriate, and necessary to maintain the individual in the community instead of placement in institutions.

B. Federal waiver requirements, as established in § 1915 of the Social Security Act and 42 CFR 430.25, provide that the average per capita fiscal year expenditures in the aggregate under the DD waivers shall not exceed the average per capita expenditures in the aggregate for the level of care provided in ICFs/IIDs, as defined in 42 CFR 435.1010 and 42 CFR 483.440, under the State Plan for Medical Assistance that would have been provided had the DD waivers not been granted.

C. DMAS shall be the single state agency pursuant to 42 CFR 431.10 responsible for administrative authority over service authorizations and delegates the processing of service authorizations and daily operations to Department of Behavioral Health and Developmental Services. DMAS shall be the single state agency authority pursuant to 42 CFR 431.10 for payment of claims for the services covered in the DD waivers and for obtaining federal financial participation from the Centers for Medicare and Medicaid Services.

D. Individuals, as defined in 12VAC30-120-501, shall have the right to appeal actions taken by DMAS or its designee, or both, consistent with 12VAC30-110.

E. Waiver service populations. These waiver services shall be provided for individuals, including children, with a developmental disability (DD) as defined in § 37.2-100 of the

Code of Virginia and who have been determined to require the level of care provided in an ICF/IID. Such services can only be covered if required by the individual to avoid institutionalization. These services shall be appropriate and necessary to ensure community integration.

F. The FIS, CL, and BI waivers services shall not be authorized or reimbursed by DMAS for an individual who resides outside of the physical boundaries of the Commonwealth. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, ICF/IID, or inpatient rehabilitation facility. Individuals with DD who are inpatients of these facilities may receive service coordination/case management services as described in 12VAC30-50-455. The support coordinator/case manager may recommend waiver services that would promote the individual's exiting from the institutional placement; however, these waiver services shall not be provided until the individual has been enrolled in the waiver.

G. An individual shall not be simultaneously enrolled in more than one waiver. An individual who has a diagnosis of DD may be on the waiting list for one of the DD waivers while simultaneously being enrolled in the Elderly or Disabled with Consumer Direction (EDCD) or the Technology Assisted waivers if he meets applicable criteria for both.

H. DMAS, or its designee, shall ensure only eligible individuals receive home and community-based waiver services and shall terminate the individual from the waiver and such services when the individual is no longer eligible for the waiver. Termination from the DD waivers shall occur when either (i) the individual's health and medical needs can no longer be safely met or (ii) when the individual is no longer eligible.

I. The individual's responses from the combination of the SIS[®] and Virginia Supplemental Questions shall determine the individual's required level of supports and establish the basis for the individual service plan.

J. No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed. No back dated payments shall be made for services that were rendered before the completion of the provider enrollment process and the individual eligibility process.

12VAC30-120-514. FIS, CL, and BI Waivers: provider enrollment, requirements, and termination.

A. No waiver services shall be reimbursed until after the provider has enrolled with DMAS and the individual eligibility process has been completed and both the provider (including consumer-directed companions and assistants) and individual are eligible and enrolled to participate. Individuals who are enrolled in the DD waivers who chose to employ their own companions or assistants prior to the completion of the provider enrollment process shall be responsible for reimbursing such costs themselves. No backdating of

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provider enrollment requirements shall be permitted in order for DMAS to pay for prematurely incurred costs.

B. DMAS or its designee shall be responsible for assuring continued adherence to provider participation standards. DMAS or its designee shall conduct ongoing monitoring of compliance with provider participation standards and applicable laws, regulations, and DMAS policies. A provider's noncompliance with applicable Medicaid laws, regulations, and DMAS policies and procedures, as required in the provider's participation agreement, may result in termination of the provider participation agreement. For DMAS to approve enrollment of a provider for home and community-based waiver services, the following standards shall be met:

1. For services that have licensure or certification requirements, the standards of any state licensure or certification requirements, or both as applicable;
2. Disclosure of ownership pursuant to 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106; and
3. The ability to document and maintain individual records in accordance with federal and state requirements.

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

1. Screen, on a monthly basis, all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal healthcare programs, including Medicaid (i.e., via the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately, upon learning of an exclusion, report in writing to DMAS such exclusion information to: DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219 or email to providerexclusion@dmass.virginia.gov.
2. Immediately notify DMAS and DBHDS, in writing, of any change in the information that the provider previously submitted for the purpose of the provider agreement to DMAS and DBHDS.
3. Assure the individual's freedom to refuse medical care, treatment, and services, and document that potential adverse outcomes that may result from refusal of services were discussed with the individual.
4. Accept referrals for services only when staff is available to initiate services within 30 calendar days and perform such services on an ongoing basis.
5. Provide services and supplies for individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794),

which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

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

7. Submit reimbursement claims to DMAS for the provision of covered services and supplies for individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by the DMAS payment methodology from the individual's authorization date for waiver services.

8. Use program-designated billing forms for submission of claims for reimbursement.

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. Provider documentation that fails to support services claimed for reimbursement may subject the provider to recovery actions by DMAS or its designee.

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

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

c. Providers shall maintain an attendance log or similar document, such as daily progress notes, that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific time frame) for each service type except for one-time services such as assistive technology, environmental modifications, transition services, individual and family caregiver training, electronic home-based services, and personal emergency response system, where initial documentation to support claims shall suffice. Such documentation shall be provided to DMAS or its designee upon request. Documentation shall not be created or modified once an audit has started.

10. Agree to furnish information on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider premises and records shall survive any termination of the provider participation agreement. No business or professional records shall be created or modified by providers, employees, or any other interested parties, either with or without the provider's knowledge, once an audit has been initiated.

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

12. Perform criminal history record checks for barrier crimes in accordance with applicable licensure requirements at § 32.1-162.9:1 or 37.2-416 of the Code of Virginia. If the individual enrolled in the waiver to be served is a minor child, also perform a search of the VDSS Child Protective Services Central Registry. The provider shall not be compensated for services provided to the individual enrolled in the waiver effective on the date that any of these records checks verifies that he has been convicted of barrier crimes described in § 32.1-162.9:1 or 37.2-416 (whichever is applicable to the provider's license) or if he has a finding in the VDSS Child Protective Services Central Registry.

a. For consumer-directed (CD) services, the CD employee shall submit to a criminal history records check conducted by the fiscal employer agent within 30 days of employment. If the individual enrolled in the waiver is a minor child, the CD employee shall also submit to a search of the VDSS Child Protective Services Central Registry. The CD employee shall not be compensated for services provided to the waiver individual effective the date on which the record check verifies that the CD employee has been convicted of barrier crimes described in § 37.2-416 of the Code of Virginia or if the CD employee has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

b. The provider or CD employer shall require direct support professionals or CD employees to notify the employer of all convictions occurring subsequent to the initial record check. Direct support professionals or CD employees who refuse to consent to VDSS Child Protective Services registry checks shall not be eligible for Medicaid reimbursement.

D. Pursuant to Subpart F of 42 CFR Part 431, 12VAC30-20-90, and any other applicable federal or state law or regulation, all providers shall hold confidential and use for DMAS or DBHDS authorized purposes only all medical assistance

information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for purposes directly related to the administration of the State Plan for Medical Assistance.

E. Change of ownership. When ownership of the provider changes, the provider shall notify DMAS at least 15 calendar days before the date of change.

F. For ICF/IID facilities covered by § 1616(e) of the Social Security Act in which respite care as a home and community-based waiver service will be provided, the facilities shall be in compliance with applicable regulatory standards.

G. Suspected abuse or neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that an individual receiving home and community-based waiver services is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report immediately at first knowledge to the local Department for Aging and Rehabilitative Services, adult protective services or the local department of social services, child protective services agency; to DMAS; and to the DBHDS Offices of Licensing and Human Rights, if applicable.

H. Adherence to provider participation agreement, Medicaid laws, and the DMAS provider manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the requirements outlined in federal and state laws, regulations, their individual provider participation agreements and in the applicable DMAS provider manual.

I. DMAS may terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. Such provider agreement terminations shall conform to 12VAC30-10-690 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20. DMAS shall not reimburse for services that may be rendered subsequent to such terminations.

J. Direct marketing. Providers are prohibited from performing any type of direct marketing activities to Medicaid individuals or their family/caregivers.

K. Providers shall participate, as may be requested, in the completion of the DBHDS-approved assessment instruments when the provider possesses specific, relevant information about the individual enrolled in the waiver.

L. Felony convictions. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the United States territories shall, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations shall be effective immediately and conform to 12VAC30-10-690. Providers shall not be reimbursed for services that may be rendered between the conviction of a

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felony and the provider's notification to DMAS of the conviction.

M. Except as otherwise provided by applicable statute or federal law, the Medicaid provider agreement may be terminated by DMAS at will on 30 days written notice. The agreement may be terminated immediately if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program. DMAS may also immediately terminate a provider's participation agreement if the provider does not fulfill its obligations as described in the provider participation agreement. Such action precludes further payment by DMAS for services provided for individuals subsequent to the date specified in the termination notice.

N. A participating provider may voluntarily terminate his participation with DMAS by providing 30 days written notification.

O. Fiscal employer/agent, as defined in 12VAC30-120-1000, requirements. Pursuant to a duly negotiated contract or interagency agreement, the contractor or entity shall be reimbursed by DMAS to perform certain employer functions including, but not limited to, payroll and bookkeeping functions on the part of the individual/employer who is receiving consumer-directed services.

1. The fiscal employer/agent shall be responsible for administering payroll services on behalf of the individual enrolled in the waiver including, but not limited to:

- a. Collecting and maintaining citizenship and alien status employment eligibility information required by the U.S. Department of Homeland Security;
- b. Securing all necessary authorizations and approvals in accordance with state and federal tax requirements;
- c. Deducting and filing state and federal income and employment taxes and other withholdings;
- d. Verifying that assistants' or companions' submitted timesheets do not exceed the maximum hours prior authorized for individuals enrolled in the waiver;
- e. Processing timesheets for payment;
- f. Making all deposits of income taxes, FICA, and other withholdings according to state and federal requirements; and
- g. Distributing biweekly payroll checks to individuals' companions and assistants.

2. All timesheet discrepancies shall be reported promptly upon their identification to DMAS for investigation and resolution.

3. The fiscal employer/agent shall maintain records and information as required by DMAS and state and federal laws and regulations and make such records available upon DMAS' request in the needed format.

4. The fiscal employer/agent shall establish and operate a customer service center to respond to individuals' and assistants'/companions' payroll and related inquiries.

5. The fiscal employer/agent shall maintain confidentiality of all Medicaid information pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and DMAS requirements. Should any breaches of confidential information occur, the fiscal/employer agent shall assume all liabilities under both state and federal law.

P. Changes to or termination of services. DMAS or its designee shall have the authority to approve changes to an individual's individual support plan, based on the recommendations of the support coordination/case management provider.

1. Service providers shall be responsible for modifying their plan for supports, with the involvement of the individual enrolled in the waiver and the individual's family/caregiver, as appropriate, and submitting such revised plan for supports to the support coordinator/case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered.

a. The support coordinator/case manager shall review the need for a change and may recommend a change to the plan for supports to the DMAS designee.

b. DBHDS shall approve, deny, or suspend for additional information, the provider's requested change or changes to the individual's plan for supports. DBHDS shall communicate its determination to the support coordinator/case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency within three business days of receipt of the request for change.

2. The individual enrolled in the waiver and the individual's family/caregiver, as appropriate, shall be notified in writing by the support coordinator/case manager of his right to appeal pursuant to DMAS client appeals regulations (Part I (12VAC30-110-10 et seq.) of 12VAC30-110) a decision to reduce, terminate, suspend, or deny services. The support coordinator/case manager shall submit this written notification to the individual enrolled in the waiver within 10 business days of the decision. Once the individual receives the written notification, the clock for filing an appeal, as set forth in the DMAS client appeals regulations, begins to run.

3. In a nonemergency situation, when a service provider determines that services to an individual enrolled in the waiver must be terminated, the service provider shall give the individual and the individual's family/caregiver, as appropriate, and support coordinator/case manager written notification of the service provider's intent to discontinue services at least 10 business days in advance of discontinuation of services. The notification letter shall provide the reasons for the planned termination and the

effective date the service provider will be discontinuing services. The effective date shall be at least 10 business days from the date of the notification letter. The individual enrolled in the waiver may pursue services from another enrolled service provider.

4. In an emergency situation when the health, safety, or welfare of the individual enrolled in the waiver, other individuals in that setting, or provider personnel are endangered, the support coordinator/case manager and DBHDS shall be notified by the service provider prior to discontinuing services. The 10-business-day prior written notification period shall not be required. The local department of social services adult protective services unit or child protective services unit, as appropriate, and the DBHDS Offices of Licensing and Human Rights shall be notified immediately by the support coordinator/case manager and the provider when the individual's health, safety, or welfare may be in danger.

5. The support coordinator/case manager shall have the responsibility to identify those individuals who no longer meet the level of functioning criteria or for whom home and community-based waiver services are no longer an appropriate alternative. In such situations, DMAS or its designee shall discharge the individuals from the waiver.

a. The support coordinator/case manager shall notify the individual and family/caregiver, as appropriate, of this determination and the right to appeal such discharge.

b. The individual shall be given the option to continue his waiver services pending the final outcome of his appeal. Should the outcome of the appeal confirm the determination by DMAS or its designee that the individual should be discharged from the waiver, the individual shall be responsible for the costs of his waiver services incurred by DMAS during his appeal.

Q. Documentation requirements for service providers.

1. The need of each individual enrolled in the waiver for each service shall be clearly set out in the individual support plan (ISP) containing each service provider's plan for supports.

2. Documentation shall confirm attendance and the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives. Observation results shall be available in at least a daily note. Data shall be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, and then clearly documented in the progress note, task analysis checklist, or support checklist.

3. Service providers shall maintain contemporaneous documentation for each unit of service delivered, and the documentation shall correspond with billing. Providers shall maintain separate documentation for each type of service rendered for an individual. Documentation shall

include all correspondence and contacts related to the individual.

4. A quarterly ISP update shall be conducted. Any update shall be reviewed by the service provider with the individual, and this written review shall be dated and submitted to the support coordinator/case manager with goals, desired outcomes, and support activities, modified as appropriate.

5. Documentation shall be maintained for routine supervision and oversight of all services provided by direct support professional staff. All significant contacts shall be documented and dated.

6. A qualified developmental disabilities professional shall provide supervision of direct support professional staff. Documentation of supervision shall be completed, signed by the staff person designated to perform the supervision and oversight, and include the following:

a. Date of contact or observation;

b. Person or persons contacted or observed;

c. A summary about direct support professional staff performance and service delivery for any monthly contacts and any semi-annual home visits;

d. Any action planned or taken to correct problems identified during supervision and oversight; and

e. On a semi-annual basis, the qualified developmental disabilities professional shall document observations concerning the individual's satisfaction with service provision.

7. Claims for payment that are not supported by supporting documentation shall be subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

R. Providers of services under any of the DD waivers shall not be the parents (natural, adoptive, foster, or step-parents) of individuals enrolled in the waiver who are minor children, or the individual's spouse. Payment shall not be made for services furnished by other family members who are living under the same roof as the individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide the care. Such other family members if approved to provide services shall meet the same provider requirements as all other licensed providers.

12VAC30-120-515. General requirements for waivers: competencies, utilization review, and quality management review (OMR).

A. Core competency requirements for direct support professionals (DSPs) and their supervisors in programs licensed by DBHDS.

1. Providers shall ensure that DSPs and DSP supervisors providing services to individuals with developmental disabilities receive training on the following core competencies:

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- a. The characteristics of developmental disabilities and Virginia's DD waivers;
- b. Person-centeredness, positive behavioral supports, effective communication;
- c. DBHDS-identified health risks and the appropriate interventions; and
- d. Best practices in the support of individuals with developmental disabilities.

2. Providers shall ensure that DSPs and DSP supervisors pass a DBHDS-approved objective, standardized test of skills, knowledge, and abilities covering the core competencies referenced above prior to providing direct, reimbursable services in the absence of other qualified staff who have passed the knowledge-based test and who document oversight of the individual who has not yet passed the test. Evidence of completed core competency training, a copy of the DSP completed test, the DBHDS-issued certificate of completion for supervisors, and documentation of assurances (DMAS Form P242a, P243a, P245a, or P246a as applicable), shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

3. Providers shall ensure that supervisors of DSPs complete the competencies checklist (DMAS Form P241a) for each DSP they supervise within 180 days of the DSP passing the DBHDS test with annual updates thereafter.

4. The director of the service provider or the director's designee shall complete the competencies checklist (DMAS Form P241a) for each DSP supervisor within 180 days of the DSP supervisor passing the DBHDS test with annual updates thereafter.

5. The checklist shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

6. Providers shall ensure that all DSPs and DSP supervisors hired on or after September 1, 2016, shall demonstrate, within 180 days of hire, the presence of the competencies listed in subsection A of this section through the administration and passage of the DBHDS-approved objective, standardized test, which shall be documented in the personnel records of each staff member and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subdivisions 3 and 4 of this subsection.

7. Providers shall ensure that DSP supervisors who were hired prior to September 1, 2016, shall be in compliance with these competency training requirements within 120 days of September 1, 2016, through the administration and passage of the DBHDS-approved objective, standardized

test, which shall be documented in the personnel records of each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

8. Providers shall ensure that DSPs who were hired prior to September 1, 2016, shall be in compliance with these competency training requirements within 180 days of September 1, 2016, through the administration and passage of the DBHDS-approved objective, standardized test, which shall be documented in the personnel records of each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subdivisions 3 and 4 of this subsection.

B. Core competency requirements for support coordinators/case managers. (Reserved.)

C. Core competency requirements for qualified developmental disabilities professionals (QDDPs). (Reserved.)

D. Advanced core competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs.

1. Providers shall ensure that DSPs and DSP supervisors supporting individuals identified as having the most intensive needs, as determined by assignment to Level 5, 6, or 7 (as referenced in 12VAC30-120-570) based on a completed Supports Intensity Scale® assessment, shall receive training specific to the individuals' needs and levels.

2. DSPs and DSP supervisors supporting individuals with extraordinary medical support needs shall receive training on advanced core competencies in the area of medical supports as established by DBHDS.

3. DSPs and DSP supervisors supporting individuals with extraordinary behavioral support needs shall receive training on advanced core competencies in the area of behavioral supports as established by DBHDS.

4. DSPs and DSP supervisors supporting individuals with autism shall receive training on advanced core competencies in the area of characteristics of autism as established by DBHDS.

5. Evidence of completed advanced core competency training through documentation of assurances completed by DSPs and DSP supervisors shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

6. Providers shall ensure that DSP supervisors complete the advanced core competencies checklists (DMAS Forms P240a, P244a, and P201) specific to the needs and levels of the individuals supported for each DSP they supervise

within 180 days of the DSP signing the documentation of assurances with annual updates thereafter.

7. The director of the provider agency or designee shall complete the advanced core competencies checklists (DMAS Forms P240a, P244a, and P201) specific to the needs and level of the individuals supported for each DSP supervisor within 180 days of the DSP supervisor signing the documentation of assurances with annual updates thereafter. The checklists shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

8. Providers shall ensure that DSPs and DSP supervisors who render services to individuals in Level 5, 6, or 7 who were hired prior to September 1, 2016, shall demonstrate the presence of the advanced core competencies listed above within 180 days of September 1, 2016, through the completion of the applicable advanced core competencies checklists based on the needs and levels of the individuals supported (DMAS Forms P240a, P244a, and P201), which shall be documented in the personnel records of each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the advanced core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subdivisions 6 and 7 of this subsection.

9. Providers shall ensure that DSPs and DSP Supervisors who render services to individuals in Level 5, 6, or 7 who are hired on or after September 1, 2016, shall demonstrate the presence of the advanced core competencies listed above within 180 days of hire through the completion of the applicable advanced core competencies checklists based on the needs and levels of the individuals supported ((DMAS Forms P240a, P244a, and P201), which shall be documented in the personnel records of each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the advanced core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subdivisions 6 and 7 of this subsection.

E. Plan for supports. The plan for supports shall include, at a minimum, the following elements:

1. The individual's strengths, desired outcomes, goals, and objectives; required or desired supports or both; and skill-building needs;

2. The individual's support activities to meet the identified outcomes;

3. The services to be rendered and the schedule for such services to accomplish the desired outcomes and support activities, a timetable for the accomplishment of the individual's desired outcomes and support activities, the estimated duration of the individual's need for services, and

the provider staff responsible for overall coordination and integration of the services specified in the plan for supports.

F. Reevaluation of service need.

1. The individual support plan (ISP).

a. The ISP shall be collaboratively developed annually by the support coordinator/case manager with the individual and the individual's family/caregiver, as appropriate, other service providers, consultants as may be needed, and other interested parties.

b. The support coordinator/case manager shall be responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the ISP as indicated by the changing needs of the individual. At a minimum, the support coordinator/case manager shall review the ISP every three months to determine whether the individual's desired outcomes and support activities are being met and whether any modifications to the ISP are necessary. The results of such reviews shall be documented in the individual's record even if no change occurred during the review period. This documentation shall be provided to DMAS and DBHDS upon request.

c. Any modification to the amount or type of services in the ISP shall be service authorized by DMAS or its designee.

d. All requests for increased waiver services by individuals enrolled in one of the DD waivers shall be reviewed by the support coordinator/case manager to ensure health, safety, and welfare and for consistency with cost effectiveness. This assures that an individual's ability to receive a waiver service is dependent on the finding that the individual needs the service, based on appropriate assessment criteria and a written plan for supports, and that services can be safely and cost effectively provided in the community.

2. Review of level of care.

a. The support coordinator/case manager shall complete a reassessment annually, at a minimum, in coordination with the individual and the individual's family/caregiver, as appropriate, and service providers. The reassessment shall include an update of the level of care and personal profile, risk assessment, and any other appropriate assessment information. The ISP shall be revised as appropriate.

b. At least every three years for those individuals who are 16 years of age and older and every two years for those individuals who are ages birth through 15 years of age, or when the individual's support needs change significantly (such as a loss of abilities that is expected to last longer than 30 days), the support coordinator/case manager, with the assistance of the individual and other appropriate parties who have knowledge of the

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individual's circumstances and needs for support, shall request an updated SIS[®] assessment and the Virginia Supplemental Questions, as appropriate, or a DBHDS-approved alternative instrument for children younger than the age of five years.

c. A medical examination shall be completed for adults based on need identified by the individual and the individual's family/caregiver, as appropriate, provider, support coordinator/case manager, or DBHDS staff. Medical examinations and screenings for children shall be completed according to the recommended frequency and periodicity of the EPSDT (42 CFR 440.40 and 12VAC30-50-130) program.

d. A new psychological or other diagnostic evaluation shall be required whenever the individual's functioning has undergone significant change (such as an increase or loss of abilities that is expected to last longer than 30 days) and is no longer reflective of the past evaluation. The evaluation shall reflect the current diagnosis, adaptive level of functioning, and presence of a functional delay that arose during the developmental period.

3. The support coordinator/case manager shall monitor the service providers' plans for supports to ensure that all providers are working toward the desired outcomes for these individuals.

4. Support coordinators/case managers shall be required to conduct and document evidence of monthly onsite visits for all individuals enrolled in the DD waivers who are residing in VDSS-licensed assisted living facilities or approved adult foster care homes. Support coordinators/case managers shall conduct and document a minimum of quarterly onsite home visits to all other individuals.

G. Utilization review and quality management reviews (QMR).

1. QMR shall be performed by the DMAS Division of Long Term Care Services or its designee. Utilization review of rendered services shall be conducted by the DMAS Division of Program Integrity or its designee.

2. DMAS staff shall conduct utilization review of individual-specific documentation.

3. DMAS shall not reimburse providers for the costs of participation in social or recreational activities.

12VAC30-120-525. FIS, CL, and BI Waivers: financial eligibility standards for individuals; criteria for services; waiver assessment and enrollment.

A. Individuals receiving services under the Family and Individual Supports (FIS) Waiver (12VAC30-120-700 et seq.), Community Living (CL) Waiver (12VAC30-120-1000 et seq.), and Building Independence (BI) Waiver (12VAC30-120-1500 et seq.), shall meet the following Medicaid eligibility requirements. The Commonwealth shall apply the

financial eligibility criteria contained in the State Plan for Medical Assistance for the categorically needy. The Commonwealth covers the optional categorically needy groups under 42 CFR 435.211, 42 CFR 435.217, and 42 CFR 435.230.

1. The income level used for 42 CFR 435.211, 42 CFR 435.217, and 42 CFR 435.230 shall be 300% of the current supplemental security income (SSI) payment standard for one person.

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

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

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

(1) The basic maintenance needs for an individual under the DD waivers, which shall be equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, shall be added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus

guardianship fees) for the individual exceed 300% of SSI.

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

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

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

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

(1) The basic maintenance needs for an individual under the DD waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, shall be added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

B. The following four criteria shall apply to all individuals who seek these waiver services:

1. The need for the DD waiver services shall arise from an individual having a diagnosed condition of DD as defined in § 37.2-100 of the Code of Virginia. Individuals qualifying for the DD waivers services shall have a demonstrated need for the covered services due to significant functional limitations in major life activities;

2. Individuals qualifying for the DD waivers services shall meet the ICF/IID level-of-care criteria as set out in 12VAC30-120-535 et seq.;

3. The services that are delivered shall be consistent with the individual support plan, service limits and requirements, and provider requirements of each service; and

4. Services shall be recommended by the support coordinator/case manager based on his documentation of the need for each specific service and as reflected in a current SIS assessment or for children younger than five years of age, an alternative industry assessment instrument approved by DBHDS, such as the Early Learning Assessment Profile.

C. Assessment and enrollment.

1. Home and community-based waiver services shall be considered only for individuals eligible for admission to an ICF/IID due to their diagnoses of DD. For the support coordinator/case manager to make a recommendation for the DD waivers services, the services shall be determined to be an appropriate service alternative to delay or avoid placement in an ICF/IID or to promote exiting from an ICF/IID or other institutional placement provided that a viable discharge plan has been developed.

2. The support coordinator/case manager shall confirm diagnostic and functional eligibility for individuals with input from the individual and the individual's family/caregiver, as appropriate, and service/support providers involved in the individual's support prior to DMAS assuming payment responsibility of home and community-based waiver services. This shall be accomplished through the completion of the following:

a. The required level-of-care determination through the Virginia Intellectual Developmental Disabilities Eligibility Survey (VIDES) appropriate to the individual according to his age, completed no more than six months prior to waiver enrollment; and

b. A psychological or other evaluation of the individual that affirms that the individual meets the diagnostic criteria for developmental disability as defined in § 37.2-100 of the Code of Virginia.

3. The individual who has been found to be eligible for these services shall be given, by the support coordinator/case manager, his choice of either institutional placement or receipt of home and community based waiver services.

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4. If the individual chooses home and community-based waiver services, the support coordinator/case manager shall recommend the individual for home and community-based waiver services.

5. If the individual selects waiver services and a slot is available, then the support coordinator/case manager shall enroll the individual in the waiver. If no slot is available, the support coordinator/case manager shall place the individual on the DD waivers waiting list consistent with criteria established for the DD waivers in 12VAC30-120-580, until such time as a slot becomes available. The CSB/BHA shall only enroll the individual following electronic confirmation by DBHDS that a slot is available.

a. Once the individual's name has been placed on the DD waivers waiting list, the support coordinator/case manager shall (i) notify the individual in writing within 10 business days of his placement on the DD waiting list and his assigned prioritization level and (ii) offer appeal rights.

b. The support coordinator/case manager shall document contact with the individual at least annually while the individual is on the waiting list to provide the choice between institutional placement and waiver services.

D. Waiver approval process: authorizing and accessing services.

1. The support coordinator/case manager shall electronically submit enrollment information to DBHDS to confirm level-of-care eligibility once he has determined (i) an individual meets the functional criteria for these waiver services, (ii) that a slot is available, and (iii) the individual has chosen waiver services.

2. Once the individual has been notified of an available waiver slot by the CSB/BHA, the support coordinator/case manager shall submit a DMAS-225 along with a computer-generated confirmation of level-of-care eligibility to the local department of social services to determine financial eligibility for Medicaid and for the waiver program and any patient pay responsibilities.

3. After the support coordinator/case manager has received written notification of Medicaid eligibility from the local department of social services, the support coordinator/case manager shall inform the individual, submit information to DMAS or its designee to enroll the individual in the waiver, and permit the development of the individual support plan (ISP).

a. The individual and the individual's family/caregiver, as appropriate, shall meet with the support coordinator/case manager within 30 calendar days of the waiver enrollment date to discuss the individual's needs and existing supports, obtain a medical examination (which shall have been completed no earlier than 12 months prior to the initiation of waiver services), begin to

develop the personal profile, and schedule the completion of the SIS[®].

b. The support coordinator/case manager shall provide the individual with choice of needed services available in the assigned waiver, alternative settings, and providers. Once the service providers are chosen, a planning meeting shall be arranged by the support coordinator/case manager to develop the ISP based on the individual's assessed needs and the preferences of the individual and the individual's family/caregiver's, as appropriate.

c. Persons invited by the support coordinator/case manager to participate in the person-centered planning meeting shall include the individual, service providers, and others as desired by the individual. During the person-centered planning meeting, the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered are identified and included in the ISP. The individual enrolled in the waiver, or the family/caregiver as appropriate, and support coordinator/case manager shall sign the ISP.

4. The individual, family/caregiver or support coordinator/case manager shall contact chosen service providers so that services can be initiated within 30 calendar days of receipt of confirmation of waiver enrollment. Enrollment occurs once the support coordinator/case manager submits the DMAS-225 form and the computer-generated confirmation of level-of-care eligibility to the local department of social services. If the services are not initiated by the provider within 30 days, the support coordinator/case manager shall notify the local department of social services so that re-evaluation of the individual's financial eligibility can be made.

5. In the case of an individual being referred back to a local department of social services for a redetermination of eligibility and in order to retain the designated slot, the support coordinator/case manager shall electronically submit information to DBHDS requesting retention of the designated slot pending the initiation of services. A copy of the request shall be provided to the individual and the individual's family/caregiver, as appropriate. DBHDS shall have the authority to approve the slot-retention request in 30-day extensions, up to a maximum of four consecutive extensions, or deny such request to retain the waiver slot for the individual. DBHDS shall provide an electronic response to the support coordinator/case manager indicating denial or approval of the slot extension request. DBHDS shall submit this response to the support coordinator/case manager within 10 working days of the receipt of the request for extension. The support coordinator/case manager shall notify the individual in writing of any denial of the slot extension request and the individual's right to appeal.

6. The service providers, in conjunction with the individual and the individual's family/caregiver, as appropriate, and the support coordinator/case manager shall develop a plan for supports for each service. Each service provider shall submit a copy of his plan to the support coordinator/case manager. The plan for supports from each service provider shall be incorporated into the ISP, along with the steps for risk mitigation as indicated by the risk assessment. The support coordinator/case manager shall review and ensure the provider-specific plan for supports meet the established service criteria for the identified needs prior to electronically submitting these along with the results of the comprehensive assessment and a recommendation for the final determination of the need for ICF/IID level of care to DMAS or its designee for service authorization. DMAS or its designee shall, within 10 working days of receiving all supporting documentation, review and approve, suspend for more information, or deny the individual service requests. DMAS or its designee shall communicate electronically to the support coordinator/case manager whether the recommended services have been approved and the amounts and types of services authorized or if any services have been denied. Only waiver services authorized on the ISP by the state-designated agency or its designee according to DMAS policies shall be reimbursed by DMAS.

7. When the support coordinator/case manager obtains the DMAS-225 form from a local department of social services, the support coordinator/case manager shall designate and inform in writing a service provider to be the collector of patient pay, when applicable. The designated provider shall monitor monthly the DMAS-designated system for changes in patient pay obligations and adjust billing, as appropriate, with the change documented in the record in accordance with DMAS policy. When the designated collector of patient pay is the consumer-directed personal or respite assistant or companion, the support coordinator/case manager shall forward a copy of the DMAS-225 form to the employer of record along with the support coordinator's/case manager's provider designation. In such cases, the support coordinator/case manager shall be required to perform the monthly monitoring of the patient pay system and shall notify the EOR of all changes.

8. DMAS shall not pay for any home and community-based waiver services delivered prior to the authorization date approved by DMAS or its designee if service authorization is required.

9. Waiver services shall be approved and authorized by the DMAS designee only if:

- a. The individual is Medicaid eligible as determined by the local department of social services;
- b. The individual, including a child, has a diagnosis of DD, as defined by § 37.2-100 of the Code of Virginia,

and would, in the absence of waiver services, require the level of care provided in an ICF/IID that would be reimbursed under the State Plan for Medical Assistance;

c. The individual's ISP is cost effective and can be safely rendered in the community; and

d. The contents of the providers' plan for supports are consistent with the ISP requirements, limitation, units, and documentation requirements of each service.

12VAC30-120-535. FIS, CL, and BI Waivers: level of functioning standards for waivers eligibility (Virginia Individual Developmental Disabilities Eligibility Survey (VIDES)).

A. 42 CFR § 441.302 mandates that DMAS ensure that individuals who are found to be eligible for § 1915(c) of the Social Security Act waivers demonstrate, at least annually, their need for the level of care provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). These waiver services shall be provided for the individuals diagnosed with a developmental disability, as defined in § 37.2-100 of the Code of Virginia, who have been determined to require the level of care provided in an ICF/IID:

B. The VIDES assessment tools shall be administered by support coordinators/case managers.

C. The results of an individual's Virginia Individual Disabilities Eligibility Survey (VIDES) determination shall be one element of determining if the individual qualifies for the FIS (12VAC30-120-700 et seq.), CL (12VAC30-120-1000 et seq.), or BI (12VAC30-120-1500 et seq.) Waiver.

D. The Commonwealth shall use VIDES forms to establish the level of care required for its DD Waivers.

1. VIDES for infants shall be used for the evaluation of individuals who are younger than three years of age (DMAS-P235).

2. VIDES for children shall be used for the evaluation of individuals who are three years of age to 18 years of age (DMAS-P-236).

3. VIDES for adults shall be used for the evaluation of individuals who are 18 years of age and older (DMAS-P237).

12VAC30-120-545. SIS® requirements; Virginia supplemental questions, and supports packages.

A. The Supports Intensity Scale (SIS®) requirements.

1. The SIS® is an assessment tool that evaluates the practical supports required by individuals to live successfully in their communities. The SIS® shall be used to assess individuals' patterns and intensity of needed supports across life activities, such as home living activities, community living activities, lifelong learning, employment, health and safety, and social activities, as well as protection and advocacy and medical and behavioral support needs. It shall be used with the Virginia

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supplemental questions to determine individual support levels.

2. The SIS[®] shall be administered and analyzed by qualified, trained interviewers designated by DBHDS.

3. The SIS[®] also assesses what is important to and important for individuals who are enrolled in a waiver.

B. The Virginia supplemental questions (VSQ) shall identify individuals who have unique needs falling outside of the needs captured by the SIS[®] instrument. It shall also be administered and analyzed by the same qualified, trained interviewers designated by DBHDS.

C. Establishment of service mix packages. (Reserved.)

12VAC30-120-570. Tiers of reimbursement.

A. Waiver services shall be reimbursed on a prospective, fee-for-service basis. There shall be no designated formal schedule for annual cost of living or other adjustments and any adjustments to provider rates shall be subject to available funding and approval by the General Assembly.

B. There shall be up to four tiers of reimbursement for some services. The approved reimbursement tier for an individual shall be based on resultant scores of the SIS[®] and Virginia supplemental questions. DBHDS shall verify the scores and levels of the individuals, as appropriate.

C. Levels of supports. The following seven levels of supports shall be applied by DMAS or its designee in the FIS, CL and BI waivers: (i) Level 1 means low support needs; (ii) Level 2 means low to moderate support needs; (iii) Level 3 means moderate support needs plus some behavior challenges; (iv) Level 4 means moderate to high support needs; (v) Level 5 means maximum support needs; (vi) Level 6 means significant support needs due to medical challenges; and (vii) Level 7 means significant support needs due to behavioral challenges.

D. Tiers of reimbursement. There shall be four as follows:

1. Tier 1 shall be used for individuals having Level 1 support needs.

2. Tier 2 shall be used for individuals having Level 2 support needs.

3. Tier 3 shall be used for individuals having either (i) Level 3 support needs or (ii) Level 4 support needs.

4. Tier 4 shall be used for individuals having (i) Level 5 support needs, (ii) Level 6 support needs, or (iii) Level 7 support needs.

E. Individual-specific support needs, such as the extraordinary medical or behavioral supports needs of some individuals, may warrant additional supports as established by criteria in the SIS, and as described below, in the following service settings: community coaching, group day services, in-home support services, group home residential services, and supported living residential services.

1. In these cases, providers and support coordinators/case managers may submit to the DMAS designee an

application for a customized reimbursement rate exceeding the reimbursement rate, according to the assessed tier. Application will include, but is not limited to, contact information, increased staffing supports needed for the individual, the types of service for which the application is made, increased program oversight needed, behavioral or medical support needs, and staffing qualifications to address the needs of the individual.

2. These requests will be reviewed by a team to ensure that there is documentation of the intense needs of the individual (whether medical, behavioral, or both) and that the provider has employed staff with higher qualifications (e.g., direct support professionals with four-year degrees) or increased the ratio of staff to individual support to 1:1 or, in the case of services already required to be provided at a 1:1 ratio, a 2:1 ratio.

3. A specialized rate methodology will be used to determine the customized reimbursement rate for each individual. These methodology components include wages, employee benefits, productivity assumptions such as training and supervision time, additional hours related to increased or specialized staffing supports, and program oversight costs.

4. Denials of customized reimbursement rates may be appealed.

5. A DMAS designee will review recipients on at least an annual basis in order to continue to receive or adjust the customized reimbursement rate.

12VAC30-120-580. Waiting list priorities; assignment process.

A. There shall be a single, statewide waiting list, called the DD waiting list, for the DD Waivers. This waiting list shall be created and maintained by DBHDS.

B. Criteria. In order to be assigned to one of the categories below, the individual shall meet one of these criteria, as appropriate:

1. Priority One shall be assigned to individuals determined to meet one of the following criteria and require a waiver service within one year:

a. An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.

b. There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:

(1) The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with

support coordinator/case manager-arranged generic or specialized supports; or

(2) There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports;

c. The individual lives in an institutional setting and has a viable discharge plan; or

d. The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.

2. Priority Two shall be assigned to individuals who meet one of the following criteria and a waiver service will be needed in one to five years:

a. The health and safety of the individual is likely to be in future jeopardy due to:

(1) 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;

(2) There are no other unpaid caregivers available to provide supports; and

(3) 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 shall be assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer 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 with adequate supports will result in a significantly improved quality of life.

C. Individuals and family/caregivers shall have the right to appeal the application of the prioritization criteria (in the event that such application results in a reduction of access to services), emergency criteria, or reserve criteria to their circumstances pursuant to 12VAC30-110. All notifications of appeal shall be submitted to DMAS.

D. Slot allocation. Individuals who are in Priority One category who are determined to be most in need of supports at

the time a slot is available are reviewed by an independent waiver slot assignment committee for the area in which the slot is available. The individual who has the highest need as designated by the committee will be recommended for the available waiver slot. The DMAS designee shall make the final determination for slot allocation.

E. Emergency access. Eligibility criteria for emergency access to either the FIS (12VAC30-120-700 et seq.), CL (12VAC30-120-1000 et seq.), or BI (12VAC30-120-1500 et seq.) waiver.

1. Subject to available funding and a finding of eligibility under 12VAC30-120-535, individuals shall meet at least one of the emergency criteria of this subdivision to be eligible for immediate access to waiver services without consideration to the length of time they have been waiting to access services. The criteria shall be one of the following:

a. Child protective services has substantiated abuse/neglect against the primary caregiver and has removed the individual from the home; or for adults where (i) adult protective services has found that the individual needs and accepts protective services or (ii) abuse/neglect has not been founded, but corroborating information from other sources (agencies) indicate that there is an inherent risk present and there are no other caregivers available to provide support services to the individual.

b. Death of primary caregiver or lack of alternative caregiver coupled with the individual's inability to care for himself and danger to self or others without supports.

2. Requests for emergency slots shall be forwarded by the CSB/BHA to DBHDS.

a. Emergency slots may be assigned by DBHDS to individuals until the total number of available emergency slots statewide reaches 10% of the emergency slots funded for a given fiscal year, or a minimum of three slots. At that point, the next nonemergency waiver slot that becomes available at the CSB in receipt of an emergency slot shall be reassigned to the emergency slot pool in order to ensure emergency slots remain to be assigned to future emergencies within the Commonwealth's fiscal year.

b. Emergency slots shall also be set aside for those individuals not previously identified but newly known as needing supports resulting from an emergent situation.

F. Reserve slots.

1. Reserve slots may be used for transitioning an individual who, due to documented changes in his support needs, requires a move from the DD waiver in which he is presently enrolled into another of the DD waivers to access necessary services.

a. An individual who needs to transition between the DD waivers shall not be placed on the DD waiting list.

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b. A documented change in an individual's assessed needs, which requires a service or services that is or are not available in the DD waiver in which the individual is presently enrolled, shall exist for an individual to be considered for a reserve slot.

c. CSBs shall document and notify DBHDS in writing when an individual meets the criteria in subdivision 1 b of this subsection within three business days of knowledge of need. The assignment of reserve slots shall be managed by DBHDS, which will maintain a chronological list of individuals in need of a reserve slot in the event that the reserve slot supply is exhausted.

2. The waiver slot belonging to the individual who vacates one of the DD waivers to utilize the reserve slot to enroll in another DD waiver shall be assigned to an individual on that CSB's/BHA's part of the statewide waiting list by DBHDS, after review and recommendations from the local waiver slot assignment committee.

G. If the individual determines at any time that he no longer wishes to be on the waiver waiting list, he may contact his support coordinator/case manager to request removal from the waiting list. The support coordinator/case manager shall notify DBHDS so that the individual's name can be removed from the waiting list.

Part VIII

Individual and Family Developmental Disabilities Support Family and Individual Supports (FIS) Waiver

Article 1

General Requirements

12VAC30-120-700. Definitions.

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

"Activities of daily living" or "ADL" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services the same as defined in 12VAC30-120-1000.

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110, Eligibility and Appeals, and 12VAC30-20-500 through 12VAC30-20-560 same as defined in 12VAC30-120-1000.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment the same as defined in 12VAC30-120-1000.

"Barrier crime" means the same as defined in 12VAC30-120-1000.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county or a combination of counties or cities or cities and counties under Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, intellectual disability, and substance abuse services in the jurisdiction or jurisdictions it serves same as defined in § 37.2-100 of the Code of Virginia.

"Case management" means services as defined in 12VAC30-50-490.

"Case manager" means the provider of case management services as defined in 12VAC30-50-490 same as defined in 12VAC30-120-1000.

"Center-based crisis support services" means the same as defined in 12VAC30-120-1000.

"Centers for Medicare and Medicaid Services" or "CMS" means the same as defined in 12VAC30-120-1000.

"Challenging behavior" means the same as defined in 12VAC30-120-1000.

"Centers for Medicare and Medicaid Services" or "CMS" means the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Community based waiver services" or "waiver services" means a variety of home and community based services paid for by DMAS as authorized under a § 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/IID placement.

"Community-based crisis supports services" means the same as defined in 12VAC30-120-1000.

"Community coaching" means the same as defined in 12VAC30-120-1000.

"Community engagement" means the same as defined in 12VAC30-120-1000.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities, or cities and counties, under Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, intellectual disability, and substance abuse services in the jurisdiction or jurisdictions it serves same as defined in § 37.2-100 of the Code of Virginia.

"Companion" means, for the purpose of these regulations, a person who provides companion services the same as defined in 12VAC30-120-1000.

"Companion services" means nonmedical care, supervision, and socialization provided to an adult (age 18 years or older).

~~The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature the same as defined in 12VAC30-120-1000.~~

~~"Comprehensive assessment" means the same as defined in 12VAC30-120-501.~~

~~"Consumer-directed employee" or "CD employee" means, for purposes of these regulations, a person who provides consumer directed services, personal care, companion services, or respite care who is also exempt from workers' compensation the same as the term "consumer-directed attendant" defined in 12VAC30-120-1000.~~

~~"Consumer directed services" means personal care, companion services, or respite care services where the individual or his family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the employee or employees.~~

~~"Consumer directed (CD) services facilitator" means the provider enrolled with DMAS who is responsible for management training and review activities as required by DMAS for consumer directed services.~~

~~"Crisis stabilization" means direct intervention for persons with related conditions who are experiencing serious psychiatric or behavioral challenges, or both, that jeopardize their current community living situation. This service must provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out of home placement. This service shall be designed to stabilize individuals and strengthen the current living situations so that individuals may be maintained in the community during and beyond the crisis period.~~

~~"Current functional status" means an individual's degree of dependency in performing activities of daily living.~~

~~"Consumer-direction" means the same as defined in 12VAC30-120-1000.~~

~~"CPR" means cardiopulmonary resuscitation.~~

~~"Crisis support services" means the same as defined in 12VAC30-120-1000.~~

~~"DARS" means the Department for Aging and Rehabilitative Services.~~

~~"Date of need" means the date of the initial eligibility determination assigned to reflect that the individual is diagnostically and functionally eligible for the waiver and is willing to begin services within 30 calendar days of the date of need. The date of need shall not be changed unless the individual is subsequently found to be ineligible, either functionally or financially, or withdraws his request for services.~~

~~"DBHDS" means the Department of Behavioral Health and Developmental Services.~~

~~"DBHDS staff" means employees of DBHDS who provide technical assistance, conduct service authorizations, and review individual level of care criteria.~~

~~"Developmental disability" or "DD" means the same as set out in § 37.2-100 of the Code of Virginia.~~

~~"Direct marketing" means the same as defined in 12VAC30-120-1000.~~

~~"Direct support professionals" or "DSPs" means the same as defined in 12VAC30-120-1000.~~

~~"DMAS" means the Department of Medical Assistance Services.~~

~~"DMAS staff" means DMAS employees who perform utilization review, preauthorize service type and intensity, and provide technical assistance persons employed by or contracted with DMAS.~~

~~"DSS" means the Department of Social Services.~~

~~"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self-care, physical development, services and support activities. These services take place outside of the individual's home/residence.~~

~~"Direct marketing" means either (i) conducting directly or indirectly door to door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual or his family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or his family/caregiver's, as appropriate, use of the providers' services.~~

~~"Electronic home-based supports" means the same as defined in 12VAC30-120-1000.~~

~~"Employer of record" or "EOR" means the same as defined in 12VAC30-120-1000.~~

~~"Enroll" means that the individual has been determined by the IFDDS screening team to meet the eligibility requirements for the waiver, DBHDS has approved the individual's plan of care and has assigned an available slot to the individual, and DSS has determined the individual's Medicaid eligibility for home and community-based services the same as defined in 12VAC30-120-501.~~

~~"Entrepreneurial model" means a small business employing eight or fewer individuals with disabilities on a shift and may~~

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~~involve interactions with the public and coworkers with disabilities.~~

~~"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals the same as defined in 12VAC30-120-1000.~~

~~"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 years according to federal guidelines that prescribe specific preventive and treatment services for Medicaid eligible children as defined in 12VAC30-50-130 same as defined in 12VAC30-120-1000.~~

~~"Face-to-face visit" means the case manager or service provider must meet with the individual in person and that the individual should be engaged in the visit to the maximum extent possible the same as defined in 12VAC30-120-1000.~~

~~"Family" means the same as defined in 12VAC30-120-501.~~

~~"Family and Individual Supports Waiver" or "FIS" means the waiver that supports individuals living with their families or friends or in their own homes. It will support individuals with some medical or behavioral needs and will be available to both children and adults.~~

~~"Family/caregiver training" means training and counseling services provided to families or caregivers of individuals receiving services in the IFDDS Waiver.~~

~~"Fiscal employer agent" means an entity handling employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer directed services the same as defined in 12VAC30-120-1000.~~

~~"Freedom of choice" means the same as defined in § 1902(a)(23) of the Social Security Act.~~

~~"General supports" means the same as defined in 12VAC30-120-1000.~~

~~"Group day services" means the same as defined in 12VAC30-120-1000.~~

~~"Group supported employment services" means the same as defined in 12VAC30-120-1000.~~

~~"Habilitation" means services and supports that help an individual keep, learn, or improve skills and functioning for daily living.~~

~~"Health, safety, and welfare standard" means the same as defined in 12VAC30-120-1000.~~

~~"Home" means, for purposes of the IFDDS Waiver, an apartment or single family dwelling in which no more than four individuals who require services live, with the exception~~

~~of siblings living in the same dwelling with family. This does not include an assisted living facility or group home.~~

~~"Home and community-based waiver services" means a variety of home and community based services reimbursed by DMAS as authorized under a § 1915(e) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/IID placement the same as defined in 12VAC30-120-1000.~~

~~"ICF/IID" means a facility or distinct part of a facility certified as meeting the federal certification regulations for an Intermediate Care Facility for Individuals with Intellectual Disabilities and persons with related conditions. These facilities must address the residents' total needs including physical, intellectual, social, emotional, and habilitation. An ICF/IID must provide active treatment, as that term is defined in 42 CFR 483.440(a) the same as defined in 12VAC30-120-1000.~~

~~"IDEA" means the federal Individuals with Disabilities Education Act of 2004, 20 USC § 1400 et seq.~~

~~"ID Waiver" means the Intellectual Disability waiver.~~

~~"IFDDS screening team" means the persons employed by the entity under contract with DMAS who are responsible for performing level of care screenings for the IFDDS Waiver.~~

~~"IFDDS Waiver," "IFDDS," or "DD" means the Individual and Family Developmental Disabilities Support Waiver.~~

~~"In-home support services" means the same as defined in 12VAC30-120-1000.~~

~~"Individual" means the same as defined in 12VAC30-120-501.~~

~~"Individual and family/caregiver training" means training and counseling services provided to individuals or families or caregivers of individuals receiving services in the FIS waiver.~~

~~"Individual supported employment" means the same as defined in 12VAC30-120-1000.~~

~~"In-home residential support services" means support provided primarily in the individual's home, which includes training, assistance, and specialized supervision to enable the individual to maintain or improve his health; assisting in performing individual care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home like environments.~~

~~"Individual Support Plan" or "ISP" means the same as defined in 12VAC30-120-1000.~~

~~"Instrumental activities of daily living" or "IADL" means meal preparation, shopping, housekeeping, laundry, and money management means the same as defined in 12VAC30-120-1000.~~

~~"Intellectual disability" or "ID" means a disability as defined by the American Association on Intellectual and~~

~~Developmental Disabilities (AAIDD) in the Intellectual Disability: Definition, Classification, and Systems of Supports (11th edition, 2010).~~

~~"LDSS" means the local Department of Social Services.~~

~~"Licensed practical nurse" means the same as defined in 12VAC30-120-1000.~~

~~"LMHP" means the same as defined in 12VAC30-50-130.~~

~~"LMHP-resident" or "LMHP-R" means the same as defined in 12VAC30-50-130.~~

~~"LMHP-resident in psychology" or "LMHP-RP" means the same as defined in 12VAC30-50-130.~~

~~"LMHP-supervisee in social work" or "LMHP-S" means the same as defined in 12VAC30-50-130.~~

~~"Medically necessary" means the same as defined in 12VAC30-120-1000.~~

~~"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS the same as defined in 12VAC30-120-1000.~~

~~"Pend" means delaying the consideration of an individual's request for authorization of services until all required information is received by DMAS or by its authorized agent the same as defined in 12VAC30-120-1000.~~

~~"Person-centered planning" means a process, directed by the individual or his family/caregiver, as appropriate, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual the same as defined in 12VAC30-120-1000.~~

~~"Personal assistance services" means the same as defined in 12VAC30-120-1000.~~

~~"Personal assistant" means the same as defined in 12VAC30-120-1000.~~

~~"Personal care provider" means a participating provider that renders services to prevent or reduce inappropriate institutional care by providing eligible individuals with personal care aides assistants to provide personal care assistance services.~~

~~"Personal care services" means long term maintenance or support services necessary to enable individuals to remain in or return to the community rather than enter an Intermediate Care Facility for Individuals with Intellectual Disabilities. Personal care services include assistance with activities of daily living, instrumental activities of daily living, access to the community, medication or other medical needs, and monitoring health status and physical condition. This does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.~~

~~"Personal emergency response system" or "PERS" means an electronic device that enables certain individuals to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of~~

~~the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision the same as defined in 12VAC30-120-1000.~~

~~"Personal profile" means the same as defined in 12VAC30-120-1000.~~

~~"Plan of care" means a document developed by the individual or his family/caregiver, as appropriate, and the individual's case manager addressing all needs of individuals of home and community based waiver services, in all life areas. Supporting documentation developed by waiver service providers is to be incorporated in the plan of care by the case manager. Factors to be considered when these plans are developed must include, but are not limited to, individuals' ages, levels of functioning, and preferences.~~

~~"Plan for supports" means the same as defined in 12VAC30-120-1000.~~

~~"Positive behavior support" means the same as defined in 12VAC30-120-1000.~~

~~"Preauthorized" means the service authorization agent has approved a service for initiation and reimbursement of the service by the service provider.~~

~~"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for such care same as defined in 12VAC30-120-1000.~~

~~"Private duty nursing" means the same as defined in 12VAC30-120-1000.~~

~~"Qualified developmental disabilities professional" or "QDDP" means a professional who (i) possesses at least one year of documented experience working directly with individuals who have related conditions; (ii) is one of the following: a doctor of medicine or osteopathy, a registered nurse, a provider holding at least a bachelor's degree in a human service field including, but not limited to, sociology, social work, special education, rehabilitation engineering, counseling or psychology, or a provider who has documented equivalent qualifications; and (iii) possesses the required Virginia or national license, registration, or certification in accordance with his profession, if applicable the same as defined in 12VAC30-120-1000.~~

~~"Registered nurse" means the same as defined in 12VAC30-120-1000.~~

~~"Related conditions" means those persons who have autism or who have a severe chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:~~

- ~~1. It is attributable to:

 - ~~a. Cerebral palsy or epilepsy; or~~
 - ~~b. Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual~~~~

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functioning or adaptive behavior similar to that of persons with intellectual disability, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22 years.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self care.
 - b. Understanding and use of language.
 - c. Learning.
 - d. Mobility.
 - e. Self direction.
 - f. Capacity for independent living.

"Respite care services" means services provided for unpaid caregivers of eligible individuals, who are unable to care for themselves and are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care the same as defined in 12VAC30-120-1000.

"Respite care provider" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing respite care services for unpaid caregivers of eligible individuals.

"Risk assessment" means the same as defined in 12VAC30-120-1000.

"Routine supports" means the same as defined in 12VAC30-120-1000.

"Safety supports" means the same as defined in 12VAC30-120-1000.

"Screening" means the process conducted by the IFDDS screening team to evaluate the medical, nursing, and social needs of individuals referred for screening and to determine eligibility for an ICF/IID level of care.

"Service authorization" means the same as defined in 12VAC30-120-1000.

"Services facilitation" means the same as defined in 12VAC30-120-1000.

"Services facilitator" means the same as defined in 12VAC30-120-1000.

"Shared living" means the same as defined in 12VAC30-120-1000.

"Significant change" means the same as defined in 12VAC30-120-1000.

"Skilled nursing services" means nursing services (i) listed in the plan of care that do not meet home health criteria, (ii) required to prevent institutionalization, (iii) not otherwise available under the State Plan for Medical Assistance, (iv) provided within the scope of the state's Nursing Act (§ 54.1-3000 et seq. of the Code of Virginia) and Drug Control Act

(§ 54.1-3400 et seq. of the Code of Virginia), and (v) provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state. Skilled nursing services are to be used to provide training, consultation, nurse delegation as appropriate, and oversight of direct care staff as appropriate same as defined in 12VAC30-120-1000.

"Slot" means an opening or vacancy of waiver services for an individual the same as defined in 12VAC30-120-501.

"Specialized supervision" means staff presence necessary for ongoing or intermittent intervention to ensure an individual's health and safety.

"State Plan for Medical Assistance" or "the State Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act same as defined in 12VAC30-120-1000.

"Supporting documentation" means the specific plan of care developed by the individual and waiver service provider related solely to the specific tasks required of that service provider. Supporting documentation helps to comprise the overall plan of care for the individual, developed by the case manager and the individual.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment.

"Support coordination/case management" means the same as defined in 12VAC30-50-455 D.

"Support coordinator/case manager" means the same as defined in 12VAC30-120-501.

"Supported living residential services" means the same as defined in 12VAC30-120-1000.

"Supports" means the same as defined in 12VAC30-120-1000.

"Supports Intensity Scale[®]" or "SIS[®]" the same as defined in 12VAC30-120-501.

"Supports level" means "the level (1-7) to which an individual is assigned as a result of the utilization of the SIS[®] score and results of the Virginia Supplemental Questions. The level of support is derived from a calculation using the SIS[®] score and the results of the Virginia Supplemental Questions and correlates to an individual's support needs.

"Therapeutic consultation" means consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy or behavior consultation to assist individuals, parents, family members,

in home residential support, day support, and any other providers of support services in implementing a plan of care the same as defined in 12VAC30-120-1000.

"Transition services" means ~~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 provides the service description, criteria, service units and limitations, and provider requirements for this service the same as defined in 12VAC30-120-2010.~~

"VDH" means the Virginia Department of Health.

"Workplace assistance services" means the same as defined in 12VAC30-120-1000.

12VAC30-120-710. General coverage Covered services and provider requirements for all home and community-based waiver Family and Individual Supports (FIS) Waiver services.

A. Waiver service populations. Home and community based services shall be available through a § 1915(e) waiver. Coverage shall be provided under the waiver for individuals six years of age or older with related conditions as defined in 12VAC30 120 700, including autism, who have been determined to require the level of care provided in an ICF/IID. The individual must not have a diagnosis of intellectual disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD). Intellectual Disability Waiver recipients who are six years of age on or after October 1, 2002, who are determined to not have a diagnosis of intellectual disability, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for and shall transfer to the IFDDS Waiver effective with their sixth birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to the child's sixth birthday. These recipients transferring from the ID Waiver will automatically be assigned a slot in the IFDDS Waiver. Such slot shall be in addition to those slots available through the screening process described in 12VAC30 120 720 B and C.

A. Except for the exclusions outlined in this subsection, individuals who are enrolled in the Family and Individual Support Waiver may choose between the agency-directed model of service delivery or the consumer-directed model for the following services: (i) personal assistance services, (ii) respite services, and (iii) companion services. The support coordinator/case manager shall collaborate with the individual, family/caregiver, and other persons desired by the individual to determine if consumer-directed services may be appropriate for the individual. Exclusions include instances where:

1. The individual who is enrolled in the waiver is younger than 18 years of age, except for emancipated minors, or is unable to be the employer of record and no one else can

assume this role in the consumer-directed model of service delivery;

2. The health, safety, or welfare of the individual enrolled in the waiver cannot be ensured via the consumer-directed model of service delivery or a back-up emergency plan cannot be developed; or

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

B. Covered services.

1. Covered services shall include ~~in-home residential supports, day support, prevocational services, supported employment, personal care (both agency directed and consumer directed), respite care (both agency directed and consumer directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems (PERS), family/caregiver training, companion services (both agency directed and consumer-directed), and transition services~~ assistive technology, center-based crisis supports services, community-based crisis supports services, community coaching, community engagement, companion services (both consumer-directed and agency-directed), crisis support services, electronic home-based supports, environmental modifications, group day services, group supported employment, individual supported employment, in-home support services, individual and family/caregiver training, personal assistance services (both consumer-directed and agency-directed), personal emergency response systems (PERS), private duty nursing, respite services (both consumer-directed and agency-directed), services facilitation (only for consumer-directed services), shared living, skilled nursing services, supported living residential, therapeutic consultation, transition services, and workplace assistance services.

2. ~~These services shall be appropriate and medically necessary to maintain these individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in ICFs/IID under the State Plan that would have been made had the waiver not been granted.~~

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

C. Eligibility criteria for emergency access to the waiver.

1. ~~Subject to available funding and a finding of eligibility under 12VAC30 120 720, individuals must meet at least one of the emergency criteria of this subdivision to be eligible for immediate access to waiver services without consideration to the length of time an individual has been~~

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~~waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home. The criteria are as follows:~~

- ~~a. The primary caregiver has a serious illness, has been hospitalized, or has died;~~
- ~~b. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate waiver services;~~
- ~~c. The individual demonstrates behaviors that present risk to personal or public safety;~~
- ~~d. The individual presents extreme physical, emotional, or financial burden at home, and the family or caregiver is unable to continue to provide care; or~~
- ~~e. The individual lives in an institutional setting and has a viable discharge plan in place.~~

~~2. When emergency slots become available:~~

- ~~a. All individuals who have been found eligible for the IFDDS Waiver but have not been enrolled shall be notified by either DBHDS or the individual's case manager.~~
- ~~b. Individuals and their family/caregivers shall be given 30 calendar days to request emergency consideration.~~
- ~~c. An interdisciplinary team of DBHDS professionals shall evaluate the requests for emergency consideration within 10 calendar days from the 30 calendar day deadline using the emergency criteria to determine who will be assigned an emergency slot. If DBHDS receives more requests than the number of available emergency slots, then the interdisciplinary team will make a decision on slot allocation based on need as documented in the request for emergency consideration. A waiting list of emergency cases will not be kept.~~

~~D. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-370. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560. 2. Individuals shall have the right to appeal as set forth in 12VAC30-120-505 D.~~

C. Core competency requirements for direct support professionals (DSPs) and their supervisors in programs licensed by DBHDS shall be the same as those set forth in 12VAC30-120-515 A.

D. Core competency requirements for support coordinators/case managers. (Reserved.)

E. Core competency requirements for QDDPs. (Reserved.)

F. Advanced core competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs shall be the same as those set forth in 12VAC30-120-515 D.

G. Provider enrollment requirements and provider participation standards shall be the same as those set forth in 12VAC30-120-514.

H. Documentation requirements shall be the same as those set forth in 12VAC30-120-514 Q.

I. Reevaluation of service need requirements shall be the same as those set forth in 12VAC30-120-515 F.

J. Utilization review requirements shall be the same as those set forth in 12VAC30-120-515 G.

12VAC30-120-720. Qualification and eligibility requirements; intake process. (Repealed.)

~~A. Individuals receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.121 and 435.217. The income level used for 42 CFR 435.121 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.~~

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

~~2. Virginia shall reduce its payment for home and community based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community based waiver services by the amount that remains after the following deductions:~~

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

~~(1) The basic maintenance needs for an individual, which is equal to 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% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to~~

exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

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

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

(1) The basic maintenance needs for an individual, which is equal to 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% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

B. Screening.

1. 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, absent a diagnosis of intellectual disability and are age six years or older. Home and community based waiver services shall be the critical service that enables the individual to remain at home rather than being placed in an ICF/IID.

2. To be eligible for IFDDS Waiver services, the individual must:

- a. Be determined to be eligible for the ICF/IID level of care;
- b. Be six years of age or older;
- c. Meet the related conditions definition as defined in 42 CFR 435.1009 or be diagnosed with autism; and
- d. Not have a diagnosis of intellectual disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD).

3. A child younger than six years of age shall not be screened until three months prior to the month of their sixth birthday. A child younger than six years of age shall not be added to the waiver or the wait list until the month in which the child's sixth birthday occurs.

4. The IFDDS screening team shall gather relevant medical and social data and identify all services received by and supports available to the individual. The IFDDS screening team shall also gather psychological evaluations or refer the individual to a private or publicly funded psychologist for evaluation of the cognitive abilities of each screening applicant.

5. The individual's status as an individual in need of IFDDS home and community-based care waiver services shall be determined by the IFDDS screening team after completion of a thorough assessment of the individual's needs and available supports. Screening for home and community-based care waiver services by the IFDDS screening team or DBHDS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care waiver services.

6. The IFDDS screening team determines the level of care by applying existing DMAS ICF/IID criteria (12VAC30-130-430).

7. The IFDDS screening team shall explore alternative settings and services to provide the care needed by the individual with the individual and his family/caregiver, as appropriate. If placement in an ICF/IID or a combination of other services is determined to be appropriate, the IFDDS screening team shall initiate a referral for service to DBHDS. If Medicaid funded home and community based waiver services are determined to be the critical service to delay or avoid placement in an ICF/IID or promote exiting

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from an institutional setting, the IFDDS screening team shall initiate a referral for service to a case manager of the individual's choice. Referrals are based on the individual choosing either ICF/IID placement or home and community based waiver services.

8. Home and community based waiver services shall not be provided to any individual who resides in a nursing facility, an ICF/IID, a hospital, an adult family care home approved by the DSS, a group home licensed by DBHDS, or an assisted living facility licensed by the DSS. However, an individual may be screened for the IFDDS Waiver and placed on the wait list while residing in one of the aforementioned facilities.

9. The IFDDS screening team must submit the results of the comprehensive assessment and a recommendation to DBHDS staff for final determination of ICF/IID level of care and authorization for home and community based waiver services.

10. For children receiving ID Waiver services prior to age six to transfer to the IFDDS Waiver during their sixth year, the individual's ID Waiver case manager shall submit to DBHDS the child's most recent Level of Functioning form, the plan of care, and a psychological examination completed no more than one year prior to transferring. Such documentation must demonstrate that no diagnosis of intellectual disability exists in order for this transfer to the IFDDS Waiver to be approved. The case manager shall be responsible for notifying DBHDS and DSS, via the DMAS 225, when a child transfers from the ID Waiver to the IFDDS Waiver. Transfers must be completed prior to the child's seventh birthday.

C. Waiver approval process: available funding.

1. In order to ensure cost effectiveness of the IFDDS Waiver, the funding available for the waiver is allocated between two budget levels. The budget is the cost of waiver services only and does not include the costs of other Medicaid covered services. Other Medicaid services, however, must be counted toward cost effectiveness of the IFDDS Waiver. All services available under the waiver are available to both levels.

2. Level one is for individuals whose comprehensive plans of care cost less than \$25,000 per fiscal year. Level two is for individuals whose plans of care costs are equal to or more than \$25,000. There is no threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF/IID care for an individual, the individual's care is case managed by DBHDS staff.

3. Fifty percent of available waiver funds are allocated to budget level one, and 40% of available waiver funds are allocated to level two in order to ensure that the waiver is cost effective. The remaining 10% of available waiver funds is allocated for emergencies as defined in 12VAC30-120-710. In order to transition an appropriate number of level one slots to emergency slots, every third level one

slot that becomes available will convert to an emergency slot until the percentage of emergency slots reaches 10%. Half of emergency slots will be allocated for individuals in institutional settings who are discharge ready and have a viable discharge plan to transition into the community within 60 days. If there are no such individuals who choose to discharge into the community when emergency slots are available for institutionalized individuals, the emergency slot will be allocated to an individual residing in the community who meets emergency criteria.

D. Assessment and enrollment.

1. The IFDDS screening team shall determine if an individual meets the functional criteria within 45 calendar days of receiving the request for screening from the individual or his family/caregiver, as appropriate. Once the IFDDS screening team determines that an individual meets the eligibility criteria for IFDDS Waiver services and the individual has chosen this service, the IFDDS screening team shall provide the individual with a list of available case managers. The individual or his family/caregiver, as appropriate, shall choose a case manager within 10 calendar days of receiving the list of case managers and the IFDDS screening team shall forward the screening materials within 10 calendar days of the case manager's selection to the selected case manager.

2. The case manager shall contact the individual within 10 calendar days of receipt of screening materials. The case manager must meet face to face with the individual and his family/caregiver, as appropriate, within 30 calendar days to discuss the individual's needs, existing supports and to develop a preliminary plan of care identifying needed services and estimating the annual waiver cost of the individual's plan of care. If the individual's annual waiver services cost is expected to exceed the average annual cost of ICF/IID care for an individual, the individual's case management shall be provided by DBHDS.

3. Once the plan of care has been initially developed, the case manager shall contact DBHDS to request approval of the plan of care and to enroll the individual in the IFDDS Waiver. DBHDS shall, within 14 calendar days of receiving all supporting documentation, either approve for Medicaid coverage or deny for Medicaid coverage the plan of care.

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

5. The following five criteria shall apply to all IFDDS Waiver services:

- a. Individuals qualifying for IFDDS Waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life

activities. In order to be eligible, an individual must be six years of age or older, have a related condition as defined in these regulations, cannot have a diagnosis of intellectual disability, and would, in the absence of waiver services, require the level of care provided in an ICF/IID facility, the cost of which would be reimbursed under the State Plan;

b. The plan of care and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the case manager based on a current functional assessment tool approved by DBHDS or other DBHDS approved assessment and demonstrated need for each specific service;

d. Individuals qualifying for IFDDS Waiver services must meet the ICF/IID level of care criteria; and

e. The individual must be eligible for Medicaid as determined by the local office of DSS.

6. DBHDS shall only authorize a waiver slot for the individual if a slot is available. If DBHDS does not have a waiver slot for this individual, the individual shall be placed on the waiting list until such time as a waiver slot becomes available for the individual.

7. DBHDS will notify the case manager when a slot is available for the individual. The case manager shall also notify the local DSS by submitting a DMAS 225 and IFDDS Level of Care Eligibility form. The case manager shall inform the individual so that the individual may apply for Medicaid if necessary and begin choosing waiver service providers for services listed in the plan of care.

8. The case manager forwards a copy of the completed DMAS 225 to DBHDS. Upon receipt of the completed DMAS 225, DBHDS shall enroll the individual into the IFDDS Waiver.

9. Once the individual has been determined to be Medicaid eligible and enrolled in the waiver, the individual or case manager shall contact the waiver service providers that the individual or his family/caregiver, as appropriate, chooses, who shall initiate waiver services within 60 calendar days. During this time, the individual, case manager, and waiver service providers shall meet to complete the provider's supporting documentation for the plan of care, implementing a person-centered planning process. The waiver service providers shall develop supporting documentation for each waiver service and shall submit a copy of this documentation to the case manager. If services are not initiated within 60 calendar days, the case manager must submit information to DBHDS demonstrating why more time is needed to initiate services and request in writing a 30 calendar day extension, up to a maximum of four consecutive extensions, for the initiation of waiver services. DBHDS must receive the request for extension letter within the 30 calendar day extension period being

requested. DBHDS will review the request for extension and make a determination within 10 calendar days of receiving the request. DBHDS has authority to approve or deny the 30 calendar day extension request.

10. The case manager shall monitor the waiver service providers' supporting documentation to ensure that all providers are working toward the identified goals of the individual. The case manager shall review and sign off on the supporting documentation. The case manager shall contact the preauthorization agent for service authorization of waiver services and shall notify the waiver service providers when waiver services are approved.

11. The case manager shall contact the individual at a minimum on a monthly basis and as needed to conduct case management activities as defined in 12VAC30-50-490. DBHDS shall conduct annual level of care reviews in which the individual is assessed to ensure continued waiver eligibility. DBHDS shall review individuals' plans of care and shall review the services provided by case managers and waiver service providers.

E. Reevaluation of service need and utilization review.

1. The plan of care.

a. The case manager shall develop the plan of care, implementing a person centered planning process with the individual, his family/caregiver, as appropriate, other service providers, and other interested parties identified by the individual or family/caregiver, based on relevant, current assessment data. The plan of care development process determines the services to be provided for individuals, the frequency of services, the type of service provided, and a description of the services to be offered. All plans of care written by the case managers must be approved by DBHDS prior to seeking authorization for services. DMAS is the single state authority responsible for the supervision of the administration of the home and community based waiver.

b. The case manager is responsible for continuous monitoring of the appropriateness of the individual's services by reviewing supporting documentation and revisions to the plan of care as indicated by the changing needs of the individual. At a minimum, every three months the case manager must:

(1) Review the plan of care face-to-face with the individual and family/caregiver, as appropriate, using a person-centered planning approach;

(2) Review individual provider quarterly reports to ensure goals and objectives are being met; and

(3) Determine whether any modifications to the plan of care are necessary, based upon the needs of the individual.

c. At least once per plan of care year this review must be performed with the individual present, and his

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family/caregivers as appropriate, in the individual's home environment.

d. ~~DBHDS staff shall review the plan of care every 12 months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the plan of care must be approved by DBHDS.~~

~~2. Annual reassessment.~~

a. ~~The case manager or DBHDS, if DBHDS is acting as the individual's case manager, shall complete an annual comprehensive reassessment, in coordination with the individual, family/caregiver, and service providers. If warranted, the case manager will coordinate a medical examination and a psychological evaluation for every waiver individual. The reassessment, completed in a person-centered planning manner, must include an update of the assessment instrument and any other appropriate assessment data.~~

b. ~~A medical examination must be completed for adults 18 years of age and older based on need identified by the individual, his family/caregiver, as appropriate, providers, the case manager, or DBHDS staff. Medical examinations for children must be completed according to the recommended frequency and periodicity of the EPSDT program.~~

c. ~~A psychological evaluation or standardized developmental assessment for children older than six years of age and adults must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation is required whenever the individual's functioning has undergone significant change and the current evaluation no longer reflects the individual's current psychological status.~~

~~3. Documentation required.~~

a. ~~The case management provider must maintain the following documentation for review by the DBHDS staff for each waiver individual:~~

~~(1) All assessment summaries and all plans of care completed for the individual are maintained for a period of not less than six years;~~

~~(2) All supporting documentation from any provider rendering waiver services for the individual;~~

~~(3) All supporting documentation related to any change in the plan of care;~~

~~(4) All related communication with the individual, his family/caregiver, as appropriate, providers, consultants, DBHDS, DMAS, DSS, DARS, or other related parties;~~

~~(5) An ongoing log documenting all contacts related to the individual made by the case manager that relate to the individual;~~

~~(6) The individual's most recent, completed level of functioning;~~

~~(7) Psychologicals;~~

~~(8) Communications with DBHDS;~~

~~(9) Documentation of rejection or refusal of services and potential outcomes resulting from the refusal of services communicated to the individual; and~~

~~(10) DMAS 225.~~

b. ~~The waiver service providers must maintain the following documentation for review by the DMAS or DBHDS staff for each waiver individual:~~

~~(1) All supporting documentation developed for that individual and maintained for a period of not less than six years;~~

~~(2) An attendance log documenting the date and times services were rendered and the amount and the type of services rendered;~~

~~(3) Appropriate progress notes reflecting the individual's status and, as appropriate, progress toward the identified goals on the supporting documentation;~~

~~(4) All communication relating to the individual. Any documentation or communication must be dated and signed by the provider;~~

~~(5) Service authorization decisions;~~

~~(6) Plans of care specific to the service being provided; and~~

~~(7) Assessments/reassessments as required for the service being provided.~~

12VAC30-120-730. General requirements for home and community-based participating providers. (Repealed.)

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

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

~~2. Assure freedom of choice for individuals seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services were performed.~~

~~3. Assure the individual's freedom to reject medical care, treatment, and services, and document that potential adverse outcomes that may result from refusal of services were discussed with the individual.~~

~~4. Accept referrals for services only when staff is available to initiate services within 30 calendar days and perform such services on an ongoing basis.~~

~~5. Provide services and supplies for individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national~~

origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

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

7. Submit charges to DMAS for the provision of services and supplies for individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS from the individual's authorization date for waiver services.

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

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

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

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

c. An attendance log or similar document must be maintained that indicates the date services were rendered, type of services rendered, and number of hours/units provided (including specific time frame).

10. Consistent with 12VAC30-120-1040, agree to furnish information on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider premises and records shall survive any termination of the provider participation agreement.

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions,

or other legal entities providing any form of health care services to individuals enrolled in Medicaid.

B. Pursuant to 42 CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable federal or state law, all providers shall hold confidential and use for DMAS or DBHDS authorized purposes only all medical assistance information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS in conjunction with the cited laws. DMAS shall not disclose medical information to the public.

C. Change of ownership. When ownership of the provider changes, the provider must notify DMAS at least 15 calendar days before the date of change.

D. For (ICF/IID) facilities covered by § 1616(e) of the Social Security Act in which respite care as a home and community based waiver service will be provided, the facilities shall be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DBHDS' licensure standards or through DSS approved standards for adult foster care providers.

E. Suspected abuse or neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community based waiver service individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DARS adult or DSS child protective services agency, as applicable, as well as to DMAS, and, if applicable, to DBHDS Offices of Licensing and Human Rights.

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

G. DMAS may terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. Such provider agreement terminations shall conform to 12VAC30-10-690 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20. DMAS shall not reimburse for services that may be rendered subsequent to such terminations.

H. Direct marketing. Providers are prohibited from performing any type of direct marketing activities to Medicaid individuals or their family/caregivers.

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12VAC30-120-735. Enrollment and voluntary or involuntary disenrollment of consumer-directed services.

A. Enrollment.

1. Individuals who are enrolled in the FIS waiver may choose between the agency-directed model of service delivery or the consumer-directed model of service delivery, or a combination of both, when DMAS makes the consumer-directed model available for care. The only services provided in this waiver that permit the consumer-directed model of service delivery shall be (i) personal assistance services, (ii) respite services, or (iii) companion services for which an individual is eligible. An individual enrolled in the waiver shall not be able to choose consumer-directed services if any of the following conditions exists:

- a. The individual enrolled in the waiver is younger than 18 years of age except for emancipated minors or is unable to be the employer of record and no one else can assume the role of EOR;
- b. The health, safety, or welfare of the individual enrolled in the waiver cannot be ensured or a back-up emergency plan cannot be developed; or
- c. The individual enrolled in the waiver has medication or skilled nursing needs or medical/behavioral conditions that cannot be safely met via the consumer-directed model of service delivery.

2. The support coordinator/case manager shall make a determination if subdivision 1 a, 1 b, or 1 c of this subsection apply. Individuals shall have the right to appeal, pursuant to 12VAC30-110, the decision if they are denied their choice of the consumer-directed service delivery model based on items described in subdivision 1 a, 1 b, or 1 c of this subsection.

B. Either voluntary or involuntary disenrollment of the individual from consumer-directed services may occur. In either voluntary or involuntary situations, the individual who is enrolled in the waiver shall be permitted to select an agency from which to receive his personal assistance, respite, or companion services. If the individual refuses to make his own selection, then either the support coordinator/case manager or the services facilitator shall make the choice for him.

1. An individual who has chosen consumer-direction may choose, at any time, to change to the agency-directed services model as long as he continues to qualify for personal assistance, respite, or companion services. The services facilitator or support coordinator/case manager, as appropriate, shall assist the individual with the change of services from consumer-directed to agency-directed.

2. The services facilitator or support coordinator/case manager, as appropriate, shall initiate involuntary disenrollment from consumer-direction of the individual who is enrolled in the waiver when any of the following conditions occur:

- a. The health, safety, or welfare of the individual enrolled in the waiver is at risk;
- b. The individual or EOR, as appropriate, demonstrates consistent inability to hire and retain an assistant or companion; or
- c. The individual or EOR, as appropriate, is consistently unable to manage the assistant or companion, as may be demonstrated by, but not limited to, a pattern of serious discrepancies with timesheets.

3. Prior to involuntary disenrollment, the services facilitator or support coordinator/case manager, as appropriate, shall:

- a. Verify that essential training has been provided to the individual or EOR, as appropriate, to improve the problem condition or conditions;
- b. Document in the individual's record the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator or support coordinator/case manager, as appropriate;
- c. Discuss with the individual or the EOR, as appropriate, the agency-directed option that is available and the actions needed to arrange for such services while providing a list of potential providers; and
- d. Provide written notice to the individual and EOR, as appropriate, of the right to appeal, pursuant to 12VAC30-110, such involuntary termination of consumer direction. Except in emergency situations in which the health or safety of the individual is at serious risk, such notice shall be given at least 10 business days prior to the effective date of the termination of consumer direction. In cases of an emergency situation, notice of the right to appeal shall be given to the individual but the requirement to provide notice at least 10 business days in advance shall not apply.

4. If the services facilitator initiates the involuntary disenrollment from consumer-direction, then he shall inform the support coordinator/case manager.

12VAC30-120-740. Participation standards for home and community-based waiver services participating providers. (Repealed.)

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

B. Provider participation standards. For DMAS to approve provider participation agreements with home and community-based waiver providers, the following standards shall be met:

1. For services that have licensure and certification requirements, licensure and certification requirements pursuant to 42 CFR 441.352.
2. Disclosure of ownership pursuant to 42 CFR 455.104 and 455.105.
3. The ability to document and maintain individual case records in accordance with state and federal requirements.

C. Adherence to provider participation agreements and special participation conditions. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their provider participation agreements.

D. Individual choice of provider entities. The individual will have the option of selecting the provider of his choice. The case manager must inform the individual of all available waiver service providers in the community in which he desires services, and he shall have the option of selecting the provider of his choice.

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

F. Termination of provider participation. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 calendar days' written notification. DMAS may terminate at will a provider's participation agreement on 30 calendar days' written notice as specified in the DMAS participation agreement. DMAS may also immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the program as determined by DMAS. Such action precludes further payment by DMAS for services provided for individuals subsequent to the date specified in the termination notice.

G. Appeals of adverse actions. A provider shall have the right to appeal adverse action taken by DMAS or its agent or DBHDS' decisions regarding the Medicaid IFDDS waiver. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

H. Termination of a provider participation agreement upon conviction of a felony. Section 32.1-325 D 2 of the Code of Virginia mandates that "any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, D.C., must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. In addition, termination of a provider participation agreement will occur as may be required for federal financial participation.

I. Case manager's responsibility for the Medicaid Long Term Care Communication Form (DMAS 225). It is the

responsibility of the case manager to notify DMAS, DBHDS, and DSS, in writing, when any of the following circumstances occur:

1. Home and community based waiver services are implemented.
2. An individual dies.
3. An individual is discharged or terminated from services.
4. Any other circumstances (including hospitalization) that cause home and community based waiver services to cease or be interrupted for more than 30 calendar days.
5. A selection by the individual or his family/caregiver, as appropriate, of a different case management provider.

J. Changes or termination of care. It is the DBHDS staff's responsibility to authorize any changes to supporting documentation of an individual's plan of care based on the recommendations of the case manager. Waiver service providers are responsible for modifying the supporting documentation with the involvement of the individual or his family/caregiver, as appropriate. The provider shall submit the supporting documentation to the case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered. The case manager shall review the need for a change and shall sign the supporting documentation if he agrees to the changes. The case manager shall submit the revised supporting documentation to the DBHDS staff to receive approval for that change. DMAS or its agent or DBHDS has the final authority to approve or deny the requested change to individual's supporting documentation. DBHDS shall notify the individual or his family/caregiver, as appropriate, in writing of the right to appeal the decision or decisions to reduce, terminate, suspend, or deny services pursuant to DMAS client appeals regulations, 12VAC30-110, Eligibility and Appeals.

1. Nonemergency termination of home and community-based waiver services by the participating provider. The participating provider shall give the individual, his family/caregiver, as appropriate, and case manager 10 calendar days' written notification of the intent to terminate services. The notification letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least 10 calendar days from the date of the termination notification letter.
2. Emergency termination of home and community based waiver services by the participating provider. In an emergency situation when the health and safety of the individual or provider is endangered, the case manager and DBHDS must be notified prior to termination. The 10 day written notification period shall not be required. When appropriate, the local DSS adult protective services or child protective services agency must be notified immediately. DBHDS Offices of Licensing and Human

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Rights must also be notified as required under the provider's license.

~~3. The DMAS termination of eligibility to receive home and community based waiver services. DMAS shall have the ultimate responsibility for assuring appropriate placement of the individual in home and community based waiver services and the authority to terminate such services to the individual for the following reasons:~~

- ~~a. The home and community based waiver service is not the critical alternative to prevent or delay institutional (ICF/IID) placement;~~
- ~~b. The individual no longer meets the institutional level of care criteria;~~
- ~~c. The individual's environment does not provide for his health, safety, and welfare; or~~
- ~~d. An appropriate and cost-effective plan of care cannot be developed.~~

~~4. In the case of termination of home and community-based waiver services by DMAS staff:~~

- ~~a. Individuals shall be notified of their appeal rights by DMAS pursuant to 12VAC30-110.~~
- ~~b. Individuals identified by the case manager who no longer meet the level of care criteria or for whom home and community based waiver services are no longer appropriate must be referred by the case manager to DMAS for review.~~

Article 2

Covered Services and Limitations and Related Provider Requirements

12VAC30-120-750. In-home residential support services, supported living residential.

A. In-home support services.

~~1. Service description. In-home residential support services shall be based primarily in the individual's home. The service shall be designed to enable individuals enrolled in the IFDDS Waiver to be maintained in their homes and shall include: (i) training in or engagement and interaction with functional skills and appropriate behavior related to an individual's health and safety, personal care, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring the individual's health, nutrition, and physical condition (iii) life skills training; (iv) cognitive rehabilitation; (v) assistance with personal care activities of daily living and use of community resources; and (vi) specialized supervision to ensure the individual's health and safety. Service providers shall be reimbursed only for the amount and type of in-home residential support services included in the individual's approved plan of care. In-home residential support services shall not be authorized in the plan of care unless the individual requires these services and these services exceed services provided by the family~~

~~or other caregiver. Services are not provided by paid staff of the in-home residential services provider for a continuous 24-hour period. The service description shall be the same as that set forth in 12VAC30-120-1028 A.~~

~~1. This service must be provided on an individual-specific basis according to the plan of care, supporting documentation, and service setting requirements.~~

~~2. Individuals may have in-home residential, personal care, and respite care in their plans of care but cannot receive these services simultaneously.~~

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

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

~~B. 2. Criteria.~~

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

~~2. A functional assessment must be conducted to evaluate each individual in his home environment and community settings.~~

~~3. Routine supervision/oversight of direct care staff. To provide additional assurance for the protection or preservation of an individual's health and safety, there are specific requirements for the supervision and oversight of direct care staff providing in-home residential support as outlined below. For all in-home residential support services provided under a DBHDS license or Rehabilitation Accreditation Commission accreditation:~~

~~a. An employee of the provider, typically by position, must be formally designated as the supervisor of each direct care staff person providing in-home residential support services.~~

~~b. The supervisor must have and document at least one supervisory contact with each direct care staff person per month regarding service delivery and direct care staff performance.~~

~~c. The supervisor must observe each direct care staff person delivering services at least semi-annually. Staff performance, service delivery in accordance with the plan of care, and evaluation of and evidence of the individual's satisfaction with service delivery by direct care staff must be documented.~~

~~d. The supervisor must complete and document at least one monthly contact with the individual or his family/caregiver, as appropriate, regarding satisfaction with services delivered by each direct care staff person.~~

~~4. The in-home residential support supporting documentation must indicate the necessary amount and type of activities required by the individual, the schedule of in-home residential support services, the total number of hours per day, and the total number of hours per week of in-home residential support. A formal, written behavioral program is required to address behaviors, including self-injury, aggression or self-stimulation.~~

~~5. Medicaid reimbursement is available only for in-home residential support services provided when the individual is present and when a qualified provider is providing the services. The criteria shall be the same as those set forth in 12VAC30-120-1028 B.~~

~~C. 3. Service units and service limitations. In-home residential supports shall be reimbursed on an hourly basis for time the in-home residential support direct care staff is working directly with the individual. Total monthly billing cannot exceed the total hours authorized in the plan of care. The provider must maintain documentation of the date, times, the services that were provided, and specific circumstances preventing the provision of any scheduled services. The service units and service limits shall be the same as those set forth in 12VAC30-120-1028 C.~~

~~4. Allowable activities shall be the same as those set forth in 12VAC30-120-1028 D.~~

~~5. Provider requirements shall be the same as those set forth in 12VAC30-120-1028 E.~~

~~D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, each in-home residential support service provider must be licensed by DBHDS as a provider of supportive residential services or have Rehabilitation Accreditation Commission accreditation. The provider must also have training in the characteristics of individuals with related conditions and appropriate interventions, strategies, and support methods for individuals with related conditions and functional limitations.~~

~~1. For DBHDS licensed programs, a plan of care and ongoing documentation of service delivery must be consistent with licensing regulations.~~

~~2. Documentation must confirm attendance and the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results must be available in at least a daily note or a weekly summary. Data must be collected as described in the plan of care, analyzed, summarized, and then clearly addressed in the regular supporting documentation.~~

~~3. The supporting documentation must be reviewed by the provider with the individual, and this written review~~

~~submitted to the case manager, at least semi-annually with goals, objectives, and activities modified as appropriate.~~

~~4. Documentation must be maintained for routine supervision and oversight of all in-home residential support direct care staff. All significant contacts described in this section must be documented. A qualified developmental disabilities professional must provide supervision of direct service staff.~~

~~5. Documentation of supervision must be completed, signed by the staff person designated to perform the supervision and oversight, and include the following:~~

- ~~a. Date of contact or observation;~~
- ~~b. Person or persons contacted or observed;~~
- ~~e. A summary about direct care staff performance and service delivery for monthly contacts and semi-annual home visits;~~
- ~~d. Semi-annual observation documentation must also address individual satisfaction with service provision;~~
- ~~e. Any action planned or taken to correct problems identified during supervision and oversight; and~~
- ~~f. Copy of the most recently completed DMAS-225 form. The provider must clearly document efforts to obtain the completed DMAS-225 form from the case manager.~~

B. Supported living residential.

1. Description. The service description shall be the same as set forth in 12VAC30-120-1036 A 1.

2. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1036 A 2.

3. Units and limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1036 A 3.

4. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1036 A 4.

12VAC30-120-751. [Reserved] Shared living.

A. Service description. The service description shall be the same as that set forth in subdivision 1 of 12VAC30-120-1034.

B. Criteria for covered services. The criteria shall be the same as those set forth in subdivision 2 of 12VAC30-120-1034.

C. Allowable activities. Allowable activities shall be the same as those set forth in subdivision 3 of 12VAC30-120-1034.

D. Covered services units and limits. Service units and limits shall be the same as those set forth in subdivision 4 of 12VAC30-120-1034.

E. Provider requirements. Provider requirements shall be the same as those set forth in subdivision 5 of 12VAC30-120-1034 and subdivision 17 of 12VAC30-120-1560.

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12VAC30-120-752. ~~Day support~~ Group day services.

~~A. Service description. Day support services shall include a variety of training, assistance, support, and specialized supervision offered in a setting (other than the home or individual residence), which allows peer interactions and community integration for the acquisition, retention, or improvement of self help, socialization, and adaptive skills. When services are provided through alternative payment sources, the plan of care shall not authorize them as a waiver funded expenditure. Service providers are reimbursed only for the amount and type of day support services included in the individual's approved plan of care based on the setting, intensity, and duration of the service to be delivered. This does not include prevocational services. The service description shall be the same as that set forth in subdivision 1 of 12VAC30-120-1026.~~

~~B. Criteria. For day support services, the individual must demonstrate the need for functional training, assistance, and specialized supervision offered in settings other than the individual's own residence that allow an opportunity for being productive and contributing members of communities. In addition, day support services will be available for individuals who can benefit from supported employment services, but who need the services as an appropriate alternative or in addition to supported employment services. The criteria shall be the same as those set forth in subdivision 2 of 12VAC30-120-1026.~~

~~1. A functional assessment must be conducted by the provider to evaluate each individual in his home environment and community settings.~~

~~2. Types and levels of day support. The amount and type of day support included in the individual's plan of care is determined according to the services required for that individual. There are two types of day support: center-based, which is provided primarily at one location/building, or noncenter based, which is provided primarily in community settings. Both types of day support may be provided at either intensive or regular levels. To be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) requires physical assistance to meet the basic personal care needs (toileting, feeding, etc.); (ii) has extensive disability related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.~~

~~C. Allowable activities shall be the same as those set forth in subdivision 3 of 12VAC30-120-1026.~~

~~C. D. Service units and service limitations. Day support cannot be regularly or temporarily provided in an individual's~~

~~home or other residential setting (e.g., due to inclement weather or individual's illness) without prior written approval from DBHDS. Noncenter based day support services must be separate and distinguishable from both in-home residential support services and personal care services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The supporting documentation must provide an estimate of the amount of day support required by the individual. The maximum is 780 units per plan of care year. If this service is used in combination with prevocational or supported employment services the combined total units for these services cannot exceed 780 units per plan of care year. Transportation shall not be billable as a day support service. The service units and limits shall be the same as those set forth in subdivision 4 of 12VAC30-120-1026.~~

~~1. One unit shall be 1 to 3.99 hours of service a day.~~

~~2. Two units are 4 to 6.99 hours of service a day.~~

~~3. Three units are 7 or more hours of service a day.~~

~~Services shall normally be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.~~

~~D. E. Provider requirements. In addition to meeting the general conditions and requirements for home and community based waiver services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, day support providers must meet the following requirements: Provider requirements shall be the same as those set forth in subdivision 5 of 12VAC30-120-1026 and 12VAC30-120-501 et seq.~~

~~1. For DBHDS programs licensed as day support programs, the plan of care, supporting documentation, and ongoing documentation must be consistent with licensing regulations. For programs accredited by Rehabilitation Accreditation Commission as day support programs, there must be supporting documentation that contains, at a minimum, the following elements:~~

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

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

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

~~d. All entities that will provide the services specified in the statement of services;~~

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

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

g. The entities responsible for the overall coordination and integration of the services specified in the plan of care.

2. Documentation must confirm the individual's attendance, the amount of the individual's time in services, and provide specific information regarding the individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results must be available in at least a daily note or a weekly summary.

a. The provider must review the supporting documentation with the individual or his family/caregiver, as appropriate, and this written review submitted to the case manager at least semi-annually with goals, objectives, and activities modified as appropriate. For the annual review and anytime the supporting documentation is modified, the revised supporting documentation must be reviewed with the individual or his family/caregiver, as appropriate.

b. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided (including specific time frame).

c. Documentation must indicate whether the services were center-based or noncenter-based and regular or intensive level.

d. If intensive day support services are requested, in order to verify which of these criteria the individual met, documentation must be present in the individual's record to indicate the specific supports and the reasons they are needed. For reauthorization of intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.

e. In instances where day support staff are required to ride with the individual to and from day support, the day support staff time may be billed as day support, provided that the billing for this time does not exceed 25% of the total time spent in the day support activity for that day. Documentation must be maintained to verify that billing for day support staff coverage during transportation does not exceed 25% of the total time spent in the day support for that day.

f. Copy of the most recently completed DMAS-225 form. The provider must clearly document efforts to obtain the completed DMAS-225 form from the case manager.

3. Supervision of direct service staff must be provided by a qualified developmental disabilities professional.

12VAC30-120-753. Prevocational services. (Repealed.)

A. Service description. Prevocational services are services aimed at preparing an individual for paid or unpaid employment, but are not job task oriented. Prevocational services are provided for individuals who are not expected to be able to join the general work force without supports or to

participate in a transitional, sheltered workshop within one year of beginning waiver services (excluding supported employment services or programs). Activities included in this service are not primarily directed at teaching specific job skills but at underlying rehabilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety.

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

C. Service units and service limitations. Billing is for one unit of service. This service is limited to 780 units per plan of care year. If this service is used in combination with day support or supported employment services, the combined total units for these services cannot exceed 780 units per plan of care year. Prevocational services may be provided in center or noncenter based settings. There must be documentation about whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). When services are provided through these sources to the individual, they will not be authorized as a waiver service. Prevocational services may only be provided when the individual's compensation is less than 50% of the minimum wage.

1. One unit shall be 1 to 3.99 hours of service a day.
2. Two units are 4 to 6.99 hours of service a day.
3. Three units are 7 or more hours of service a day.

Services shall normally be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community based services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, prevocational services providers must also meet the following requirements:

1. The prevocational services provider must be a vendor of extended employment services, long term employment services, or supported employment services for DARS, or be licensed by DBHDS as a day support services provider. Providers must ensure and document that persons providing prevocational services have training in the characteristics of related conditions, appropriate interventions, training strategies, and support methods for individuals with related conditions and functional limitations.

2. Required documentation in the individual's record. The provider must maintain a record for each individual receiving prevocational services. At a minimum, the record must contain the following:

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a. A functional assessment conducted by the provider to evaluate each individual in the prevocational environment and community settings.

b. A plan of care containing, at a minimum, the following elements (DBHDS licensing regulations require the following for plans of care):

(1) The individual's needs and preferences;

(2) Relevant psychological, behavioral, medical, rehabilitation, and nursing needs as indicated by the assessment;

(3) Individualized strategies including the intensity of services needed;

(4) A communication plan for individuals with communication barriers including language barriers; and

(5) The behavior treatment plan, if applicable.

3. The plan of care must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and with written results of these reviews submitted to the case manager. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual or his family/caregiver, as appropriate.

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

5. In instances where prevocational staff are required to ride with the individual to and from prevocational services, the prevocational staff time may be billed for prevocational services, provided that the billing for this time does not exceed 25% of the total time spent in prevocational services for that day. Documentation must be maintained to verify that billing for prevocational staff coverage during transportation does not exceed 25% of the total time spending the prevocational services for that day.

6. A copy of the most recently completed DMAS 225. The provider must clearly document efforts to obtain the completed DMAS 225 from the case manager.

12VAC30-120-754. Supported Group supported employment services; individual supported employment; workplace assistance services.

A. Service description Group supported employment.

1. Service description. The service description shall be the same as set forth in 12VAC30-120-1035 A.

1. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to enable an individual to maintain paid employment. Each supporting documentation must confirm whether supported employment services are available to the individual in vocational rehabilitation agencies through the

Rehabilitation Act of 1973 or in special education services through 20 USC § 1401 of the Individuals with Disabilities Education Act (IDEA). Providers of these DARS and IDEA services cannot be reimbursed by Medicaid with the IFDDS Waiver funds. Waiver service providers are reimbursed only for the amount and type of habilitation services included in the individual's approved plan of care based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of supported employment, not for the amount of time the recipient is in the supported employment environment.

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

B. 2. Criteria for receipt of services. The criteria shall be the same as set forth in 12VAC30-120-1035 B.

1 Only job development tasks that specifically include the individual are allowable job search activities under the IFDDS FIS Waiver supported employment and only after determining this service is not available from DARS or IDEA.

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

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

4. The supporting documentation must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the plan of care based on the intensity and duration of the service delivered.

3. Allowable activities shall be the same as those set forth in 12VAC30-120-1035 C.

C. 4. Service units and service limitations shall be the same as set forth in 12VAC30-120-1035 D.

1 Supported employment for individual job placement is provided in one hour units. This service is limited to 40 hours per week. The unit of service shall be one hour.

Services shall not exceed 66 hours per week. The 66-hour weekly limit may include a combination of the following: group supported employment services, individual supported employment, community engagement, community coaching, workplace assistance services, and group day services.

2. Group models of supported employment (enclaves, work crews, bench work, and entrepreneurial model of supported employment) will be billed according to the DMAS fee schedule.

3 Supported employment services are limited to 780 units per plan of care year. If used in combination with prevocational and day support services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per plan of care year.

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

~~D~~ Provider 5. Group supported employment provider requirements. In addition to meeting the general conditions and requirements for home and community based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, supported employment providers must meet the following requirements: The provider requirements shall be the same as set forth in 12VAC30-120-1035 E.

1. Supported employment services shall be provided by agencies that are programs certified by the Rehabilitation Accreditation Commission to provide supported employment services or are DARS vendors of supported employment services.

2. Individual ineligibility for supported employment services through DARS or IDEA must be documented in the individual's record, as applicable. If the individual is ineligible to receive services through IDEA, documentation is required only for lack of DARS funding. Acceptable documentation would include a copy of a letter from DARS or the local school system or a record of a telephone call (name, date, person contacted) documented in the case manager's case notes, Consumer Profile/Social assessment or on the supported employment supporting documentation. Unless the individual's circumstances change, the original verification may be forwarded into the current record or repeated on the supporting documentation or revised Social Assessment on an annual basis.

3. Supporting documentation and ongoing documentation consistent with licensing regulations, if a DBHDS licensed program.

4. For non DBHDS programs certified as supported employment programs, there must be supporting

documentation that contains, at a minimum, the following elements:

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

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

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

~~d. All entities that will provide the services specified in the statement of services;~~

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

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

~~g. Entities responsible for the overall coordination and integration of the services specified in the plan of care.~~

5. Documentation must confirm the individual's attendance, the amount of time the individual spent in services, and must provide specific information regarding the individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results should be available in at least a daily note or weekly summary.

6. The provider must review the supporting documentation with the individual, and this written review submitted to the case manager, at least semi annually, with goals, objectives, and activities modified as appropriate. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual or his family/caregiver, as appropriate.

7. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time may be billed as supported employment provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day. Documentation must be maintained to verify that billing supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.

8. There must be a copy of the completed DMAS 225 form in the record. Providers must clearly document efforts to obtain the DMAS 225 form from the case manager.

B. Individual supported employment services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1035 A.

2. Criteria for receipt of services. The criteria shall be the same as those set forth in 12VAC30-120-1035 B.

3. Allowable activities. The allowable activities shall be the same as those set forth in 12VAC30-120-1035 C.

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4. Service units and service limitations. The service units and limitations shall be the same as those set forth in 12VAC30-120-1035 D.

5. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1035 E.

C. Workplace assistance services.

1. Service description. The service description shall be the same as set forth in 12VAC30-120-1039 A.

2. Service criteria. The service criteria shall be the same as those set forth in 12VAC30-120-1039 B.

3. Allowable activities. The allowable activities shall be the same as those set forth in 12VAC30-120-1039 C.

4. Service units and service limitations. Service units and limits shall be the same as those set forth in 12VAC30-120-1039 D.

5. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1039 E.

12VAC30-120-756. Therapeutic consultation.

~~A. Service description. Therapeutic consultation provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and service providers in supporting the individual. The specialty areas include the following: psychology, social work, occupational therapy, physical therapy, therapeutic recreation, rehabilitation, psychiatry, psychiatric clinical nursing, behavioral consultation, and speech/language therapy. These services may be provided, based on the individual's plan of care, for those individuals for whom specialized consultation is clinically necessary to enable their utilization of waiver services and who have additional challenges restricting their ability to function in the community. Therapeutic consultation services may be provided in the individual's home, in other appropriate community settings, and in conjunction with another waiver service. These services are intended to facilitate implementation of the individual's desired outcomes as identified in the individual's plan of care. Therapeutic consultation service providers are reimbursed according to the amount and type of service authorized in the plan of care based on an hourly fee for service. The service description shall be the same as that set forth in 12VAC30-120-1037 A.~~

~~B. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the plan of care cannot be implemented effectively and efficiently without such consultation from this service. The criteria shall be the same as those set forth in 12VAC30-120-1037 B.~~

~~1. The individual's plan of care must clearly reflect the individual's needs, as documented in the social assessment, for specialized consultation provided to family/caregivers~~

~~and providers in order to implement the plan of care effectively.~~

~~2. Therapeutic consultation services may not include direct therapy provided to individuals receiving waiver services, or monitoring activities, and may not duplicate the activities of other services that are available to the individual through the State Plan of Medical Assistance.~~

~~C. Service units and service limitations limits. The unit of service shall equal one hour. Service units and limits shall be the same as those set forth in 12VAC30-120-1037 C.~~

~~The services must be explicitly detailed in the supporting documentation. Travel time, written preparation, and telephone communication are in kind expenses within this service and are not billable as separate items.~~

~~Therapeutic consultation may not be billed solely for purposes of monitoring. Therapeutic consultations shall be available to individuals who are receiving at least one other waiver service and case management services.~~

~~D. Allowable activities. Allowable activities shall be the same as those set forth in 12VAC30-120-1037 D.~~

~~D. E. Provider requirements. In addition to meeting the general conditions and requirements for home and community based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, professionals rendering therapeutic consultation services, including behavior consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation shall be rehabilitation engineers or certified rehabilitation specialists. Behavioral consultation may be performed by professionals based on the professional's knowledge, skills, and abilities as defined by DMAS. Provider requirements shall be the same as those set forth in 12VAC30-120-1037 E.~~

~~1. Supporting documentation for therapeutic consultation. The following information is required in the supporting documentation:~~

~~a. Identifying information: individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for supporting documentation; and semi annual review dates, if applicable;~~

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

~~c. Specific consultation activities; and~~

~~d. A written support plan detailing the interventions or support strategies.~~

~~2. Monthly and contact notes shall include:~~

~~a. Summary of consultative activities for the month;~~

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

~~c. Supporting documentation objectives addressed;~~

~~d. Specific details of the activities conducted;~~

- e. Services delivered as planned or modified; and
 - f. Effectiveness of the strategies and individuals' and caregivers' satisfaction with service.
3. Semi annual reviews are required by the service provider if consultation extends three months or longer, are to be forwarded to the case manager, and must include:
- a. Activities related to the therapeutic consultation supporting documentation;
 - b. Individual status and satisfaction with services; and
 - c. Consultation outcomes and effectiveness of support plan.
4. If consultation services extend less than three months, the provider must forward monthly contact notes or a summary of them to the case manager for the semi annual review.
5. A written support plan, detailing the interventions and strategies for providers, family, or caregivers to use to better support the individual in the service.
6. A final disposition summary must be forwarded to the case manager within 30 calendar days following the end of this service and must include:
- a. Strategies utilized;
 - b. Objectives met;
 - c. Unresolved issues; and
 - d. Consultant recommendations.

12VAC30-120-758. Environmental modifications (EM).

A. Service description. Environmental modifications shall be defined as those physical adaptations to the individual's primary home or primary vehicle used by the individual documented in the individual's plan of care, that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the primary home and, without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repairs, central air conditioning, etc. Adaptations that add to the total square footage of the home shall be excluded from this benefit, except when necessary to complete an adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications must be authorized by the service authorization agent. Modifications may be made to a vehicle if it is the primary vehicle being used by the individual. This service does not include the purchase of

vehicles. The service description shall be the same as set forth in 12VAC30-120-1025 B 1.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. Environmental modifications shall be covered in the least expensive, most cost effective manner. For enrollees in the Elderly or Disabled with Consumer Direction (EDCD) waiver (12VAC30-120-900 through 12VAC30-120-980), environmental modification services shall be available only to those EDCD enrollees who are also enrolled in the Money Follows the Person demonstration. The criteria shall be the same as those set forth in 12VAC30-120-1025 B 2.

C. Service units and service limitations. Environmental modifications shall be available to individuals who are receiving case management services. To receive environmental modifications in the EDCD waiver, the individual must be receiving at least one other waiver service. To receive environmental modifications in the IFDDS waiver, the individual must be receiving case management services and at least one other waiver service. A maximum limit of \$5,000 may be reimbursed per plan of care or calendar year, as appropriate to the waiver in which the individual is enrolled. Costs for environmental modifications shall not be carried over from year to year. All environmental modifications must be authorized by the service authorization agent prior to billing. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act. Case managers or transition coordinators must, upon completion of each modification, meet face to face with the individual and his family/caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual. The service units and limits shall be the same as those set forth in 12VAC30-120-1025 B 3.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community based waiver services participating providers as specified in 12VAC30-120-160, 12VAC30-120-730, 12VAC30-120-740, and 12VAC30-120-930, as appropriate, environmental modifications must be provided in accordance with all applicable state or local building codes by contractors who have a provider agreement with DMAS. Providers may not be spouses or parents of the individual. Modifications must be completed within the plan of care or the calendar year in which the modification was authorized, as appropriate to the

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waiver in which the individual is enrolled. Provider requirements shall be the same as those set forth in 12VAC30-120-1025 B 4.

12VAC30-120-759. [Reserved] Services facilitation.

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

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

2. The services facilitator shall assess the individual's particular needs for a requested consumer-directed service, assist in the development of the plan for supports, provide management training for the individual or the EOR, as appropriate, on his responsibilities as employer, and provide ongoing support of the consumer-directed model of services. The service authorization for receipt of consumer directed services shall be based on the approved plan for supports.

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

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

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

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

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

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

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

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

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

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

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

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

g. Any other services received and the amount.

5. The services facilitator, during routine visits, shall also review and verify timesheets as needed to ensure that the number of hours approved in the plan for supports is not exceeded. If discrepancies are identified, the services facilitator shall discuss these with the individual or the EOR to resolve discrepancies and shall notify the fiscal/employer agent. If an individual is consistently identified as having discrepancies in his timesheets, the services facilitator shall contact the support coordinator/case manager to resolve the situation. Failure to review and verify timesheets and maintain

documentation of such reviews shall subject the provider to recovery of payments made by DMAS in accordance with 12VAC30-80-130.

6. The services facilitator shall maintain a record of each individual containing elements as set out in 12VAC30-120-770.

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

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

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

10. The consumer-directed services facilitator, who is to be reimbursed by DMAS, shall not be the individual enrolled in the waiver, the individual's support coordinator/case manager, a direct service provider, the individual's spouse, a parent, including stepparents and legal guardians, of the individual who is a minor child, or the EOR who is employing the assistant/companion.

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

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

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

a. In order to be approved to use the consumer-directed model of services, the individual enrolled in the waiver, or if the individual is unable, the designated EOR, shall

have the capability to hire, train, and fire his own assistants/companions and supervise the assistants/companions' performance. Support coordinators/case managers shall document in the individual support plan the individual's choice for the consumer-directed model and whether or not the individual chooses services facilitation. The support coordinator/case manager shall document in this individual's record that the individual can serve as the EOR or if there is a need for another person to serve as the EOR on behalf of the individual.

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

c. Specific employer duties shall include checking references of assistants/companions, determining that assistants/companions meet specified qualifications, timely and accurate completion of hiring packets, training the assistants/companions, supervising assistants/companions' performance, and submitting complete and accurate timesheets to the fiscal/employer agent on a consistent and timely basis.

B. Participation standards for provision of services; providers' requirements.

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the services facilitator provider shall have sufficient resources to perform the required activities, including the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. All CD services facilitators, whether employed by or contracted with a DMAS enrolled services facilitator provider, shall meet all of the qualifications set out in this subsection. To be enrolled, the services facilitator shall also meet the combination of work experience and relevant education set out in this subsection that indicate the possession of the specific knowledge, skills, and abilities to perform this function. The services facilitator shall maintain a record of each individual containing elements as set out in this section.

a. If the services facilitator is not an RN, then, within 30 days from the start of such services, the services facilitator shall inform the primary health care provider for the individual enrolled in the waiver that consumer-directed services are being provided and request skilled nursing or other consultation as needed by the individual. Prior to contacting the primary health care provider, the services facilitator shall obtain the individual's written consent to make such contact or contacts. All such contacts and consultations shall be documented in the individual's medical record. Failure to document such contacts and consultations shall be subject to DMAS' recovery of payments made.

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b. Prior to enrollment by DMAS as a consumer-directed services facilitator, applicants shall possess, at a minimum, either (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and two years of satisfactory direct care experience supporting individuals with disabilities or older adults or children or (ii) a bachelor's degree in a non-health or human services field and a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults or children.

c. All consumer-directed services facilitators, shall:

(1) Have a satisfactory work record as evidenced by two references from prior job experiences from any human services work; such references shall not include any evidence of abuse, neglect, or exploitation of the elderly, persons with disabilities, or children;

(2) Submit to a criminal background check within 15 days of employment. The results of such check shall contain no record of conviction of barrier crimes as set forth in § 32.1-162.9:1 of the Code of Virginia. Proof that the criminal record check was conducted shall be maintained in the record of the services facilitator. In accordance with 12VAC30-80-130, DMAS shall not reimburse the provider for any services provided by a services facilitator who has been convicted of committing a barrier crime as set forth in § 32.1-162.9:1 of the Code of Virginia;

(3) Submit to a search of the DSS Child Protective Services Central Registry yielding no founded complaint; and

(4) Not be debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at <https://exclusions.oig.hhs.gov>.

d. The services facilitator shall not be compensated for services provided to the waiver individual after the initial or a subsequent background check verifies that the services facilitator (i) has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia; (ii) has a founded complaint confirmed by the DSS Child Protective Services Central Registry; or (iii) is found to be listed on the LEIE.

e. All consumer-directed services facilitators providers and staff employed by consumer-directed services facilitator providers to function as a consumer-directed services facilitator shall complete the DMAS-approved consumer-directed services facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being approved as a consumer-directed services facilitator or being reimbursed for working with waiver individuals. The competency

assessment and all corresponding competency assessments shall be kept in the employee's record.

f. Failure to complete the competency assessment within the 90-day time limit and meet all other requirements shall result in a retraction of Medicaid payment or the termination of the provider agreement, or both.

g. As a component of the renewal of the provider agreement, all consumer-directed services facilitators shall take and pass the competency assessment every five years and achieve a score of at least 80%.

h. The consumer-directed services facilitator shall have access to a computer with secure Internet access that meets the requirements of 45 CFR Part 164 for the electronic exchange of information. Electronic exchange of information shall include, for example, checking individual eligibility, submission of service authorizations, submission of information to the fiscal employer agent, and billing for services.

i. All consumer-directed services facilitators shall possess a demonstrable combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities shall be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview shall be documented. The knowledge, skills, and abilities include:

(1) Knowledge of:

(a) Types of functional limitations and health problems that may occur in individuals with intellectual disability or individuals with other developmental disabilities, as well as strategies to reduce limitations and health problems;

(b) Physical assistance that may be required by individuals with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications that may be required by individuals with developmental disabilities that reduce the need for human help and improve safety;

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

(e) DD Waivers requirements, as well as the administrative duties for which the services facilitator will be responsible;

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

- (g) Interviewing techniques;
- (h) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance, companion, and respite services, including hiring, training, managing, approving timesheets, and firing an assistant/companion;
- (i) The principles of human behavior and interpersonal relationships; and
- (j) General principles of record documentation.
- (2) Skills in:
 - (a) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;
 - (b) Assessing, supporting, observing, recording, and reporting behaviors;
 - (c) Identifying, developing, or providing services to individuals with developmental disabilities; and
 - (d) Identifying services within the established services system to meet the individual's needs.
- (3) Abilities to:
 - (a) Report findings of the assessment or onsite visit, either in writing or an alternative format, for individuals who have visual impairments;
 - (b) Demonstrate a positive regard for individuals and their families;
 - (c) Be persistent and remain objective;
 - (d) Work independently, performing position duties under general supervision;
 - (e) Communicate effectively, orally and in writing; and
 - (f) Develop a rapport and communicate with individuals of diverse cultural backgrounds.

2. The services facilitator's record about the individual shall contain:

- a. Documentation of all employer management training provided to the individual enrolled in the waiver and the EOR, as appropriate, including the individual's or the EOR's, as appropriate, receipt of training on his responsibility for the accuracy and timeliness of the assistant's/companion's timesheets; and
- b. All documents signed by the individual enrolled in the waiver or the EOR, as appropriate, which acknowledge their legal responsibilities as the employer.

12VAC30-120-760. Skilled nursing services; private duty nursing services.

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

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

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

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

- ~~1. If a home health agency, be certified by the VDH for Medicaid participation and have a current DMAS provider participation agreement for private duty nursing;~~
- ~~2. Demonstrate a prior successful health care delivery business or practice;~~
- ~~3. Operate from a business office; and~~
- ~~4. If community services boards or behavioral health authority employ or subcontract with and directly supervise a registered nurse (RN) or a licensed practical nurse (LPN) with a current and valid license issued by the Virginia State Board of Nursing, the RN or LPN must have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, or nursing home.~~

A. Skilled nursing services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1031 A 1.
2. Services criteria. The criteria shall be the same as that set forth in 12VAC30-120-1031 A 2.
3. Allowable activities. Allowable activities shall be the same as that set forth in 12VAC30-120-1031 A 3.
4. Skilled nursing services units and limits. Service units and limits shall be the same as that set forth in 12VAC30-120-1031 A 4.
5. Skilled nursing services provider requirements. Provider requirements shall be the same as that set forth in 12VAC30-120-1031 A 5.

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B. Private duty nursing services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1031 B 1.
2. Private duty nursing services criteria. The criteria shall be the same as those set forth in 12VAC30-120-1031 B 2.
3. Private duty nursing services allowable activities. Allowable activities shall be the same as those set forth in 12VAC30-120-1031 B 3.
4. Private duty nursing services service units and limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1031 B 4.
5. Private duty nursing services provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1031 B 5.

12VAC30-120-761. ~~{Reserved}~~ Community engagement; community coaching; community guide.

A. Community engagement.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1022 A 1.
2. Community engagement criteria. Criteria shall be the same as those set forth in 12VAC30-120-1022 A 2.
3. Community engagement allowable activities. Allowable activities shall be the same as those set forth in 12VAC30-120-1022 A 3.
4. Community engagement service units and service limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1022 A 4.
5. Community engagement provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1022 A 5 and 12VAC30-120-1065 A.

B. Community coaching.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1022 B 1.
2. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1022 B 2.
3. Allowable activities. The allowable activities shall be the same as those set forth in 12VAC30-120-1022 B 3.
4. Service units and service limits. The service units and limits shall be the same as those set forth in 12VAC30-120-1022 B 4.
5. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1022 B 5 and 12VAC30-120-1065 B.

C. Community guide. (Reserved.)

12VAC30-120-762. Assistive technology (AT).

~~A. Service description. Assistive technology (AT) is available to recipients who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. AT is the specialized medical equipment and supplies, including those devices, controls, or~~

~~appliances, specified in the plan of care, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items. The service description is the same as set forth in 12VAC30-120-1021 A.~~

~~B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. Assistive technology shall be covered in the least expensive, most cost effective manner. For enrollees in the Elderly or Disabled with Consumer Direction (EDCD) waiver (12VAC30 120 900 through 12VAC30 120 980), assistive technology services shall be available only to those EDCD enrollees who are also enrolled in the Money Follows the Person demonstration. The criteria are the same as set forth in 12VAC30-120-1021 A 1.~~

~~C. Service units and service limitations. AT is available to individuals receiving at least one other waiver service and may be provided in the individual's home or community setting. A maximum limit of \$5,000 may be reimbursed per plan of care year or the calendar year, as appropriate to the waiver in which the individual is enrolled or calendar year, as appropriate to the waiver being received. Costs for assistive technology cannot be carried over from year to year and must be preauthorized each plan of care year. AT will not be approved for purposes of convenience of the caregiver/provider or restraint of the individual. Service units and limitations are the same as those set forth in 12VAC30-120-1021 A 2.~~

~~An independent, professional consultation must be obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by the prior authorization agent, and may include training on such AT by the qualified professional. All AT must be authorized by the service authorization agent prior to billing. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.~~

~~D. Provider Service requirements. In addition to meeting the general conditions and requirements for home and community based care participating providers as specified in 12VAC30 120 160, 12VAC30 120 730, 12VAC30 120 740, and 12VAC30 120 930, AT shall be provided by providers having a current provider participation agreement with DMAS as durable medical equipment and supply providers.~~

~~Independent, professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Service requirements are the same as those set forth in 12VAC30-120-1021 A 3.~~

~~Providers that supply AT for an individual may not perform assessment/consultation, write specifications, or inspect the AT for that individual. Providers of services may not be spouses or parents of the individual.~~

~~AT must be delivered within the plan of care year, or within a year from the start date of the authorization, as appropriate to the waiver, in which the individual is enrolled.~~

~~E. Provider requirements. Provider requirements are the same as those set forth in 12VAC30-120-1021 A 4 and 12VAC30-120-1061 A and B.~~

12VAC30-120-764. Crisis stabilization services support services (such as prevention, intervention, stabilization); center-based crisis supports; community-based crisis supports.

~~A. Service description. Crisis stabilization services involve direct interventions that provide temporary, intensive services and supports that avert emergency, psychiatric hospitalization or institutional placement of individuals who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services shall include, as appropriate, neuropsychological, psychiatric, psychological and other functional assessments and stabilization techniques, medication management and monitoring, behavior assessment and support, and intensive care coordination with other agencies and providers. This service is designed to stabilize the individual and strengthen the current living situation so that the individual remains in the community during and beyond the crisis period.~~

~~These services shall be provided to:~~

- ~~1. Assist planning and delivery of services and supports to enable the individual to remain in the community;~~
- ~~2. Train family members, other care givers, and service providers in supports to maintain the individual in the community; and~~
- ~~3. Provide temporary crisis supervision to ensure the safety of the individual and others.~~

~~B. Criteria.~~

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

 - ~~a. The individual is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;~~
 - ~~b. The individual is experiencing extreme increase in emotional distress;~~
 - ~~c. The individual needs continuous intervention to maintain stability; or~~
 - ~~d. The individual is causing harm to self or others.~~~~

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

- ~~a. Psychiatric hospitalization;~~
- ~~b. Emergency ICF/IID placement;~~
- ~~c. Disruption of community status (living arrangement, day placement, or school); or~~
- ~~d. Causing harm to self or others.~~

~~C. Service units and service limitations. Crisis stabilization services must be authorized following a documented face to face assessment conducted by a qualified developmental disabilities professional (QDDP).~~

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

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

- ~~a. The home of an individual who lives with family or other primary caregiver or caregivers;~~
- ~~b. The home of an individual who lives independently or semi-independently to augment any current services and support;~~
- ~~c. A day program or setting to augment current services and supports; or~~
- ~~d. A respite care setting to augment current services and supports.~~

~~3. Crisis supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided one-on-one and face to face with the individual. Crisis supervision, if provided as a part of this service, shall be billed separately in hourly service units.~~

~~4. Crisis stabilization services shall not be used for continuous long term care. Room and board and general supervision are not components of this service.~~

~~5. If appropriate, the assessment and any reassessments shall be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.~~

~~D. Provider requirements. In addition to the general conditions and requirements for home and community based waiver services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, the following crisis stabilization provider requirements apply:~~

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~~1. Crisis stabilization services shall be provided by entities licensed by DBHDS as a provider of outpatient, residential, supportive in home services, or day support services. The provider must employ or utilize qualified licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities for individuals with related conditions who require crisis stabilization services. Supervision of direct service staff must be provided by a QDDP. Crisis supervision providers must be licensed by DBHDS as providers of residential services, supportive in home services, or day support services.~~

~~2. Crisis stabilization supporting documentation must be developed (or revised, in the case of a request for an extension) and submitted to the case manager for authorization within 72 hours of the face-to-face assessment or reassessment.~~

~~3. Documentation indicating the dates and times of crisis stabilization services, the amount and type of service provided, and specific information about the individual's response to the services and supports as agreed to in the supporting documentation must be recorded in the individual's record.~~

~~4. Documentation of provider qualifications must be maintained for review by DMAS staff. This service shall be designed to stabilize the individual and strengthen the current semi-independent living situation, or situation with family or other primary care givers, so the individual can be maintained during and beyond the crisis period.~~

A. Service description.

1. Crisis support services. The service definition shall be the same as that set forth in 12VAC30-120-1024 A 1.

a. Crisis prevention. The service description shall be the same as that set forth in 12VAC30-120-1024 A 1 a.

b. Crisis intervention. The service definition shall be the same as that set forth in 12VAC30-120 A 1 b.

c. Crisis stabilization. The service description shall be the same as that set forth in 12VAC30-120-1024 A 1 c.

2. Center-based crisis supports. The service definition shall be the same as set forth in 12VAC30-120-1024 A 2.

3. Community-based crisis supports. The service definition shall be the same as set forth in 12VAC30-120-1024 A 3.

B. Criteria.

1. Crisis support services. The criteria shall be the same as those set forth in 12VAC30-120-1024 B 1.

2. Center-based crisis supports. The criteria shall be the same as those set forth in 12VAC30-120-1024 B 2.

3. Community-based crisis supports. The criteria shall be the same as those set forth in 12VAC30-120-1024 B 3.

C. Allowable activities.

1. Crisis support services. Allowable activities shall be the same as those set forth in 12VAC30-120-1024 C 1 and C 2.

2. Center-based crisis supports. Allowable activities shall be the same as those set forth in 12VAC30-120-1024 C 3.

3. Community-based crisis supports. Allowable activities shall be the same as those set forth in 12VAC30-120-1024 C 4.

D. Service units and service limitations.

1. Crisis support services. Service units and limits shall be the same as those set forth in 12VAC30-120-1024 D 1.

2. Center-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024 D 2.

3. Community-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024 D 3.

E. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1024 E and 12VAC30-120-1063.

12VAC30-120-766. Personal care and respite care assistance, services, and companion services.

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal care services means services offered to individuals in their homes and communities to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. This service shall provide care to individuals with activities of daily living (eating, drinking, personal hygiene, toileting, transferring and bowel/bladder control), instrumental activities of daily living (IADL), access to the community, monitoring of self-medication or other medical needs, and the monitoring of health status or physical condition. In order to receive personal care services, the individual must require assistance with their ADLs.

When specified in the plan of care, personal care services may include assistance with IADL. Assistance with IADL must be essential to the health and welfare of the individual, rather than the individual's family/caregiver.

An additional component to personal care is work or school related personal care. This allows the personal care provider to provide assistance and supports for individuals in the workplace and for those individuals attending postsecondary educational institutions. Workplace or school supports through the IFDDS Waiver are not provided if they are services that should be provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act,

the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work related personal care services cannot duplicate services provided under supported employment.

2. Respite care means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care.

A. Personal assistance services.

1. Service description. The service description for personal assistance services shall be the same as that set forth in 12VAC30-120-1029 B.

2. Criteria. The criteria for personal assistance services shall be the same as those set forth in 12VAC30-120-1029 C.

3. Allowable activities. Allowable activities for personal assistance services are the same as those set forth in 12VAC30-120-1029 C 3.

4. Service units and service limitations. Service units and service limitations for personal assistance are the same as those set forth in 12VAC30-120-1029 D.

5. Provider requirements. Provider requirements for personal assistance are the same as those set forth in 12VAC30-120-1029 E and 12VAC30-120-1059.

B. Criteria: Respite services.

1. In order to qualify for personal care services, the individual must demonstrate a need in activities of daily living, reminders to take medication, or other medical needs, or monitoring health status or physical condition. Service description. The service description shall be the same as that set forth in 12VAC30-120-1032 B.

2. In order to qualify for respite care, individuals must have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual. The criteria for respite services shall be the same as those set forth in 12VAC30-120-1032 C.

3. Individuals choosing the consumer directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770. Allowable activities for respite services shall be the same as those set forth in 12VAC30-120-1032 D.

4. Service units and service limitations. Service units and service limitations for respite services shall be the same as those set forth in 12VAC30-120-1032 E.

5. Provider requirements for respite services shall be the same as those set forth in 12VAC30-120-1032 F and 12VAC30-120-1059.

C. Service units and service limitations:

1. The unit of service is one hour.

2. Effective July 1, 2011, respite care services are limited to a maximum of 480 hours per year. Individuals who are receiving services through both the agency directed and consumer directed models cannot exceed 480 hours per year combined.

3. Individuals may have personal care, respite care, and in-home residential support services in their plan of care but cannot receive in home residential supports and personal care or respite care services at the same time.

4. Each individual receiving personal care services must have a back up plan in case the personal care aide or consumer directed (CD) employee does not show up for work as expected or terminates employment without prior notice.

5. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.

6. Individuals shall be permitted to share personal care service hours with one other individual (receiving waiver services) who lives in the same home.

7. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, personal and respite care providers must meet the following provider requirements:

1. Services shall be provided by:

a. For the agency directed model, a DMAS enrolled personal care/respite care provider or by a DBHDS-licensed residential supportive in-home provider. All personal care aides must pass an objective standardized test of knowledge, skills, and abilities approved by DBHDS and administered according to DBHDS' defined procedures. Providers must demonstrate a prior successful health care delivery business and operate from a business office.

b. For the consumer directed model, a service facilitation provider meeting the requirements found in 12VAC30-120-770.

2. For DBHDS licensed providers, a residential supervisor shall provide ongoing supervision for all personal care aides

For DMAS enrolled personal care/respite care providers, the provider must employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all aides. The supervising RN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

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~~3. The RN supervisor or case manager/services facilitator must make a home visit to conduct an initial assessment prior to the start of care for all individuals requesting services. The RN supervisor or case manager/service facilitator must also perform any subsequent reassessments or changes to the supporting documentation. Under the consumer directed model, the initial comprehensive visit is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.~~

~~4. The RN supervisor or case manager/services facilitator must make supervisory visits as often as needed to ensure both quality and appropriateness of services.~~

~~a. For personal care the minimum frequency of these visits is every 30 to 90 calendar days depending on individual needs. For respite care offered on a routine basis, the minimum frequency of these visits is every 30 to 90 calendar days under the agency directed model and every six months or upon the use of 240 respite care hours (whichever comes first) under the consumer directed model.~~

~~b. Under the agency directed model, when respite care services are not received on a routine basis, but are episodic in nature, the RN is not required to conduct a supervisory visit every 30 to 90 calendar days. Instead, the RN supervisor must conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.~~

~~c. When respite care services are routine in nature and offered in conjunction with personal care, the 30 day to 90 day supervisory visit conducted for personal care may serve as the RN supervisor or case manager/service facilitator visit for respite care. However, the RN supervisor or case manager/services facilitator must document supervision of respite care separately. For this purpose, the same record can be used with a separate section for respite care documentation.~~

~~5. Under the agency directed model, the supervisor shall identify any gaps in the aide's ability to provide services as identified in the individual's plan of care and provide training as indicated based on continuing evaluations of the aide's performance and the individual's needs.~~

~~6. The supervising RN or case manager/services facilitator must maintain current documentation. This may be done as a summary and must note:~~

~~a. Whether personal and respite care services continue to be appropriate;~~

~~b. Whether the supporting documentation is adequate to meet the individual's needs or if changes are indicated in the supporting documentation;~~

~~c. Any special tasks performed by the aide/CD employee and the aide's/CD employee's qualifications to perform these tasks;~~

~~d. Individual's satisfaction with the service;~~

~~e. Any hospitalization or change in the individual's medical condition or functioning status;~~

~~f. Other services received and their amount; and~~

~~g. The presence or absence of the aide in the home during the RN's visit.~~

~~7. Qualification of aides/CD employees. Each aide/CD employee must:~~

~~a. Be 18 years of age or older and possess a valid social security number;~~

~~b. For the agency directed model, be able to read and write English to the degree necessary to perform the tasks required. For the consumer directed model, possess basic math, reading and writing skills;~~

~~c. Have the required skills to perform services as specified in the individual's plan of care;~~

~~d. Not be the parents of individuals who are minors, or the individual's spouse. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the qualifications. In addition, under the consumer directed model, family/caregivers acting as the employer on behalf of the individual may not also be the CD employee;~~

~~e. Additional aide requirements under the agency directed model:~~

~~(1) Complete an appropriate aide training curriculum consistent with DMAS standards. Prior to assigning an aide to an individual, the provider must ensure that the aide has satisfactorily completed a training program consistent with DMAS standards. DMAS requirements may be met in any of the following ways:~~

~~(a) Registration as a certified nurse aide (DMAS-enrolled personal care/respite care providers);~~

~~(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant or home health aide (DMAS-enrolled personal care/respite care providers);~~

~~(c) Completion of provider offered training that is consistent with the basic course outline approved by DMAS (DMAS-enrolled personal care/respite care providers);~~

~~(d) Completion and passing of the DBHDS standardized test (DBHDS-licensed providers);~~

(2) Have a satisfactory work record as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

(3) Be evaluated in his job performance by the supervisor.

f. Additional CD employee requirements under the consumer directed model:

(1) Submit to a criminal records check and, if the individual is a minor, the child protective services registry. The employee will not be compensated for services provided to the individual if the records check verifies the employee has been convicted of crimes described in § 37.2-314 of the Code of Virginia or if the employee has a complaint confirmed by the DSS child protective services registry;

(2) Be willing to attend training at the request of the individual or his family/caregiver, as appropriate;

(3) Understand and agree to comply with the DMAS consumer directed services requirements; and

(4) Receive an annual TB screening.

8. Provider inability to render services and substitution of aides (agency directed model). When an aide is absent, the provider may either obtain another aide, obtain a substitute aide from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider.

9. Retention, hiring, and substitution of employees (consumer directed model). Upon the individual's request, the CD services facilitator shall provide the individual or his family/caregiver, as appropriate, with a list of consumer directed employees on the consumer directed employee registry that may provide temporary assistance until the employee returns or the individual or his family/caregiver, as appropriate, is able to select and hire a new employee. If an individual or his family/caregiver, as appropriate, is consistently unable to hire and retain an employee to provide consumer directed services, the services facilitator must contact the case manager and DBHDS to transfer the individual, at the choice of the individual or his family/caregiver, as appropriate, to a provider that provides Medicaid funded agency directed personal care or respite care services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

10. Required documentation in individuals' records. The provider must maintain all records of each individual receiving services. Under the agency directed model, these records must be separated from those of other nonwaiver services, such as home health services. At a minimum these records must contain:

a. The most recently updated plan of care and supporting documentation, all provider documentation, and all DMAS 225 forms;

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

c. Nurses' or case manager/services facilitator summarizing notes recorded and dated during any contacts with the aide or CD employee and during supervisory visits to the individual's home;

d. All correspondence to the individual, to DBHDS, and to DMAS;

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

f. Under the agency directed model, all aide records. The aide record must contain:

(1) The specific services delivered to the individual by the aide and the individual's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered;

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

(5) Signatures, times, and dates; these signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered; and

(6) Copies of all aide records; these records shall be subject to review by state and federal Medicaid representatives.

g. Additional documentation requirements under the consumer directed model:

(1) All management training provided to the individuals or their family caregivers, as appropriate, including responsibility for the accuracy of the timesheets.

(2) All documents signed by the individual or his family/caregivers, as appropriate, that acknowledge the responsibilities of the services.

C. Companion services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1023 A.

2. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1023 B.

3. Service units and service limitations. The service units and limits shall be the same as those set forth in 12VAC30-120-1023 C.

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4. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1023 D and 12VAC30-120-1059.

12VAC30-120-770. Consumer-directed model of service delivery.

A. Criteria.

1. The ~~IFDDS~~ FIS Waiver has three services, companion, personal care, and respite services, that may be provided through a consumer-directed model.

2. Individuals who are eligible for consumer-directed services must have the capability to hire, train, and fire their consumer-directed employees and supervise the employee's work performance. If an individual is unable to direct his own care or is younger than 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

3. Responsibilities as employer. The individual, or if the individual is unable, then a family/caregiver, is the employer in this service and is responsible for hiring, training, supervising, and firing employees. Specific duties include checking references of employees, determining that employees meet basic qualifications, training employees, supervising the employees' performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or his family/caregiver, as appropriate, must have an emergency back-up plan in case the employee does not show up for work.

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

5. Individuals choosing consumer-directed services must receive support from a CD services facilitator. Services facilitators assist the individual or his family/caregiver, as appropriate, as they become employers for consumer-directed services. This function includes providing the individual or his family/caregiver, as appropriate, with management training, review and explanation of the Employee Management Manual, and routine visits to monitor the employment process. The CD services facilitator assists the individual/employer with employer issues as they arise. The services facilitator meeting the stated qualifications may also complete the assessments, reassessments, and related supporting documentation necessary for consumer-directed services if the individual or his family/caregiver, as appropriate, chooses for the CD services facilitator to perform these tasks rather than the case manager. Services facilitation services are provided

on an as-needed basis as determined by the individual, family/caregiver, and CD services facilitator. This must be documented in the supporting documentation for consumer-directed services and the services facilitation provider bills accordingly. If an individual enrolled in consumer-directed services has a lapse in consumer-directed services for more than 60 consecutive calendar days, the case manager shall notify DBHDS so that consumer-directed services may be discontinued and the option given to change to agency-directed services.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, services facilitators providers must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitation provider and maintain provider status, the CD services facilitation provider must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the service facilitation and support activities as required. It is preferred that the employee of the CD services facilitation provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator has two years of satisfactory experience in the human services field working with individuals with related conditions.

2. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Various long-term care program requirements, including nursing home, ICF/IID, and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care services;

(2) DMAS consumer-directed services requirements, and the administrative duties for which the individual will be responsible;

(3) Interviewing techniques;

(4) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets, and firing an employee;

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

(6) General principles of record documentation.

(7) For CD services facilitators who also conduct assessments and reassessments, the following is also required. Knowledge of:

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

(b) Physical assistance typically required by people with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications commonly used and required by people with developmental disabilities that reduces the need for human help and improves safety; and

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

b. Skills in:

(1) Negotiating with individuals or their family/caregivers, as appropriate, and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to persons with developmental disabilities; and

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

c. Abilities to:

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

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

(3) Be persistent and remain objective;

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

(5) Communicate effectively, orally and in writing;

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

(7) Interview.

3. If the CD services facilitator is not an RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

a. If the services facilitator has responsibility for individual assessments and reassessments, these must be conducted as specified in 12VAC30-120-766 and 12VAC30-120-776.

b. Management training.

(1) The CD services facilitation provider must make an initial visit with the individual or his family/caregiver, as appropriate, to provide management training. The initial management training is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation providers, the new CD services facilitator must bill for a regular management training in lieu of initial management training.

(2) After the initial visit, two routine visits must occur within 60 days of the initiation of care or the initial visit to monitor the employment process.

(3) For personal care services, the CD services facilitation provider will continue to monitor on an as needed basis, not to exceed a maximum of one routine visit every 30 calendar days but no less than the minimum of one routine visit every 90 calendar days per individual. After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months and for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first.

5. The CD services facilitator must be available to the individual or his family/caregiver, as appropriate, by telephone during normal business hours, have voice mail capability, and return phone calls within 24 hours or have an approved back-up CD services facilitator.

6. The CD services fiscal contractor for DMAS must submit a criminal record check within 15 calendar days of employment pertaining to the consumer-directed employees on behalf of the individual or family/caregiver and report findings of the criminal record check to the individual or his family/caregiver, as appropriate.

7. The CD services facilitator shall verify bi-weekly timesheets signed by the individual or his family caregiver, as appropriate, and the employee to ensure that the number of plan of care approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must contact the individual to resolve discrepancies and must notify the fiscal agent. If an individual is consistently being identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation.

8. Consumer-directed employee registry. The CD services facilitator must maintain a consumer-directed employee registry, updated on an ongoing basis.

9. Required documentation in individuals' records. CD services facilitators responsible for individual assessment and reassessment must maintain records as described in 12VAC30-120-766 and 12VAC30-120-776. For CD services facilitators conducting management training, the following documentation is required in the individual's record:

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- a. All copies of the plan of care, all supporting documentation related to consumer-directed services, and all DMAS-225 forms.
- b. CD services facilitator's notes recorded and dated at the time of service delivery.
- c. All correspondence to the individual, to others concerning the individual, and to DMAS and DBHDS.
- d. All training provided to the consumer-directed employees on behalf of the individual or his family/caregiver, as appropriate.
- e. All management training provided to the individuals or his family/caregivers, as appropriate, including the responsibility for the accuracy of the timesheets.
- f. All documents signed by the individual or his family/caregiver, as appropriate, that acknowledge the responsibilities of the services.

12VAC30-120-773. ~~[Reserved]~~ Electronic-based home supports (EBHS).

A. Service description. The service description shall be the same as that set forth in 12VAC30-120-1025 A 1.

B. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1025 A 2.

C. Service limits and service limitations. The service limits and units shall be the same as those set forth in 12VAC30-120-1025 A 3.

D. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1025 A 4.

12VAC30-120-774. Personal emergency response system (PERS).

~~A. Service description. PERS is a service that monitors individual safety in the home 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 individual's home telephone line. PERS may also include medication monitoring devices. The service description shall be the same as set forth in 12VAC30-120-1030 A 1.~~

~~B. Criteria. PERS may be authorized when there is no one else in the home who is competent or continuously available to call for help in an emergency. The criteria shall be the same as set forth in 12VAC30-120-1030 A 2.~~

~~C. Service units and service limitations. Service units and limits shall be the same as set forth in 12VAC30-120-1030 A 3.~~

~~1. 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 one month rental price set by DMAS. The one time installation of the unit includes installation, account activation, individual and caregiver instruction, and removal of PERS equipment.~~

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

~~3. PERS cannot be used as a substitute for providing adequate supervision of the individual.~~

~~D. Provider requirements. In addition to meeting the general conditions and requirements for home and community based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, providers must also meet the following requirements: Provider requirements shall be the same as those set forth in 12VAC30-120-1030 A 4 and 12VAC30-120-1560 P.~~

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

~~2. The PERS provider must provide an emergency response center staff 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 as appropriate, days per year; of determining whether an emergency exists; and of notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.~~

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

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

~~5. The PERS provider must properly install all PERS equipment into the functioning telephone line of an individual receiving PERS and must furnish all supplies necessary to ensure that the system is installed and working properly.~~

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

7. A PERS provider must maintain all installed PERS equipment in proper working order.

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

- a. Delivery date and installation date of the PERS;
- b. The signature of the individual or his family/caregiver, as appropriate, verifying receipt of PERS device;
- c. Verification by a test that the PERS device is operational, monthly or more frequently as needed;
- d. Updated and current individual responder and contact information, as provided by the individual or the individual's care provider, or case manager; and
- e. A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, case manager, or responder.

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

10. Standards for PERS equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation ensuring that subsequent signals can be transmitted without requiring manual reset by the individual.

11. A PERS provider must furnish education, data, and ongoing assistance to DBHDS and case managers to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the individual, his family/caregiver, as appropriate, and responders in the use of the PERS service.

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

13. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all

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

- a. A primary receiver and a back up receiver, which must be independent and interchangeable;
- b. A back up information retrieval system;
- c. A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- d. A back up power supply;
- e. A separate telephone service;
- f. A toll free number to be used by the PERS equipment in order to contact the primary or back up response center; and
- g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

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

15. The PERS provider shall document and furnish within 30 calendar days of the action taken a written report to the case manager for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or activations made in error.

16. The PERS provider is prohibited from performing any type of direct marketing activities.

12VAC30-120-775. [Reserved] Transition services.

Transition services shall be consistent with the requirements and limits set out in 12VAC30-120-1038, 12VAC30-120-2000, and 12VAC30-120-2010.

12VAC30-120-776. Companion services. (Repealed.)

A. Service description. Companion services is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to ensure their safety during times when no other supportive people are available. This service may be provided either through an agency directed or a consumer directed model.

B. Criteria.

- 1. The inclusion of companion services in the plan of care is appropriate only when the individual cannot be left alone at any time due to mental or severe physical incapacitation.

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This includes individuals who cannot use a phone to call for help due to a physical or neurological disability. Individuals may receive companion services due to their inability to call for help if PERS is not appropriate for them.

2. Individuals having a current, uncontrolled medical condition making them unable to call for help during a rapid deterioration may be approved for companion services if there is documentation that the individual has had recurring attacks during the two month period prior to the authorization of companion services. Companion services shall not be covered if required only because the individual does not have a telephone in the home or because the individual does not speak English.

3. There must be a clear and present danger to the individual as a result of being left unsupervised. Companion services cannot be authorized for individuals whose only need for companion services is for assistance exiting the home in the event of an emergency.

4. Individuals choosing the consumer directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations:

1. The amount of companion service time included in the plan of care must be no more than is necessary to prevent the physical deterioration or injury to the individual. In no event may the amount of time relegated solely to companion service on the plan of care exceed eight hours per day.

2. A companion cannot provide supervision to individuals on ventilators, requiring continuous tube feedings, or requiring suctioning of their airways.

3. Companion services will be authorized for family members to sleep either during the day or during the night when the individual cannot be left alone at any time due to the individual's severe agitation or physically wandering behavior. Companion services must be necessary to ensure the individual's safety if the individual cannot be left unsupervised due to health and safety concerns.

4. Companion services may be authorized when no one else is in the home is competent to call for help in an emergency.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, companion service providers must meet the following requirements:

1. Companion services providers shall include:

a. For the agency directed model: companion providers include DBHDS licensed residential services providers; DBHDS licensed supportive, in-home residential service providers; DBHDS licensed day support service

providers; DBHDS licensed respite service providers; and DMAS-enrolled personal care/respite care providers.

b. For the consumer directed model: a services facilitator must meet the requirements found in 12VAC30-120-770.

2. Companion qualifications. Companions must meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic math skills and English reading and writing skills, to the degree necessary to perform the tasks required;

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

d. Submit to a criminal history record check and if providing services to a minor, submit to a record check under the State's Child Protective Services Registry. The companion will not be compensated for services provided to the individual if the records check verifies the companion has been convicted of crimes described in § 37.2-416 of the Code of Virginia;

e. Possess a valid social security number; and

f. Have the required skills to perform services as specified in the individual's plan of care.

g. Additional CD employee requirements under the consumer directed model:

(1) Be willing to attend training at the request of the individual or his family/caregiver, as appropriate;

(2) Understand and agree to comply with the DMAS consumer directed services requirements; and

(3) Receive an annual TB screening.

3. Companions may not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective, written documentation as to why there are no other providers available to provide the services. Companion services shall not be provided by adult foster care/family care providers or any other paid caregivers.

4. Family members who are reimbursed to provide companion services must meet the companion qualifications.

5. For the agency directed model, companions are employees of entities that enroll with DMAS to provide companion services. Providers are required to have a companion services supervisor to monitor companion services. The supervisor must be an LPN, or an RN, have a current license or certification to practice in the Commonwealth, and have at least one year of experience working with individuals with related conditions; or must have a bachelor's degree in a human services field and at least one year of experience working with individuals with related conditions.

6. Retention, hiring, and substitution of companions (consumer directed model). Upon the individual's request, the CD services facilitator shall provide the individual or his family/caregiver, as appropriate, with a list of potential consumer directed employees on the consumer directed employee registry that may provide temporary assistance until the companion returns or the individual or his family/caregiver as, appropriate, is able to select and hire a new companion. If an individual or his family/caregiver, as appropriate, is consistently unable to hire and retain a companion to provide consumer directed services, the CD services facilitator must contact the case manager and DBHDS to transfer the individual, at the choice of the individual or his family/caregiver, as appropriate, to a provider that provides Medicaid funded agency directed companion services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

7. The provider or case manager/services facilitator must conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of services and to establish a plan of care for the individual. Under the agency directed model, the provider must provide follow up home visits quarterly or as often as needed to monitor the provision of services. Under the consumer directed model, the case manager/services facilitator will periodically review the utilization of companion services at a minimum of every six months or more often as needed. The individual must be reassessed for services every six months.

8. Required documentation. The provider or case manager/services facilitator must maintain a record of each individual receiving companion services. At a minimum these records must contain the following:

- a. An initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation.
- b. The supporting documentation must be reviewed by the provider or case manager/services facilitator quarterly under the agency directed model, semiannually under the consumer directed model, annually, and more often, as needed, modified as appropriate, and the written results of these reviews submitted to the case manager. For the annual review and in cases where the supporting documentation is modified, the plan of care must be reviewed with the individual or his family/caregiver, as appropriate.
- c. All correspondence to the individual, family/caregiver, case manager, DBHDS, and DMAS.
- d. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- e. The companion services supervisor or case manager/service facilitator must document in the

individual's record a summary note following significant contacts with the companion and quarterly or semiannual home visits with the individual. This summary must include the following at a minimum:

- (1) Whether companion services continue to be appropriate;
- (2) Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;
- (3) The individual's satisfaction with the service; and
- (4) The presence or absence of the companion during the visit.

f. A copy of the most recently completed DMAS 225 form. The provider must clearly document efforts to obtain the completed DMAS 225 form from the case manager.

g. Additional documentation requirements under the consumer directed model:

- (1) All training provided to the companion on behalf of the individual or his family/caregiver, as appropriate.
- (2) All management training provided to the individual or his family/caregiver, as appropriate, including responsibility for the accuracy of the timesheets.
- (3) All documents signed by the individual or his family/caregiver, as appropriate, that acknowledge the responsibilities of the services.

h. Under the agency directed model, all companion records. The companion record must contain the following:

- (1) The specific services delivered to the individual by the companion, dated the day of service delivery, and the individual's response;
- (2) The companion's arrival and departure times;
- (3) The companion's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and
- (4) The weekly signatures of the companion and the individual or his family/caregiver, as appropriate, recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

12VAC30-120-777. [Reserved] Companion services (both consumer-directed and agency-directed).

A. Service description. The service description shall be the same as that set forth in 12VAC30-120-1023 A.

B. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1023 B.

C. Service units and service limitations. The service units and service limitations shall be the same as those set forth in 12VAC30-120-1023 C.

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D. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1023 D and 12VAC30-120-1059.

12VAC30-120-779. [Reserved] Individual and family/caregiver training.

A. Service description. This service provides training and counseling services to individuals, families, or caregivers of individuals enrolled in the waiver including participation in education opportunities designed to improve the family's or caregiver's ability to care for and support the individual enrolled in the waiver. This service shall also provide educational opportunities for the individual to better understand his disability and increase his self-determination and self-advocacy.

B. Criteria. Any individuals who are enrolled in this waiver and their family/caregivers, as appropriate, may participate in this service. DMAS shall cover this service as authorized by the individual's plan for supports.

C. Service units and limits.

1. This service may be authorized for up to 80 hours per ISP year.

2. Travel and room and board expenses shall not be covered.

D. Provider requirements.

1. Providers shall have a signed, current provider participation agreement with DMAS in order to be reimbursed for providing individual and family/caregiver training.

2. Providers shall have the necessary licensure or certification as required for their profession (i.e., RNs shall have a current license to practice nursing in the Commonwealth or hold a multistate licensure privilege).

3. This service shall be provided by enrolled provider entities with expertise in, experience in, or demonstrated knowledge of the training topic set out in the plan for supports.

4. This service may be provided through seminars and conferences organized by the enrolled provider entities.

5. This service may also be provided by individual practitioners who have experience in or demonstrated knowledge of the training topics. This may include psychologists, teachers or educators, social workers, medical personnel, personal care providers, therapists, and providers of other services such as day and residential supports.

6. Qualified provider types include:

- a. Staff of home health agencies;
- b. Staff of community developmental disabilities services agencies;
- c. Staff of developmental disabilities residential providers;

d. Staff of community mental health centers;

e. Staff of public health agencies, hospitals, clinics, or other agencies/organizations; and

f. Individual practitioners including licensed or certified personnel such as RNs, LPNs, psychologists, speech/language therapists, occupational therapists, physical therapists, licensed clinical social workers, licensed behavior analysts, and persons with other education, training, or experience directly related to the specified needs of the individual as set out in the ISP.

12VAC30-120-782. Payment for services.

A. All shared living, supported living residential, in-home supports, group day services, community engagement, community coaching, workplace assistance services, personal assistance (both agency-directed and consumer-directed), respite services (both agency directed and consumer directed), skilled nursing, private duty nursing, therapeutic consultation, center-based crisis support services, community-based crisis support services, crisis support services, PERS, environmental modifications, assistive technology, companion (both agency-directed and consumer-directed), individual and family/caregiver training, consumer-directed services facilitation, and transition services provided in this waiver shall be reimbursed consistent with DMAS service limits and payment amounts as set out in the fee schedule.

B. Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same services. Reimbursement rates for group supported employment shall be as set by DMAS.

C. All EHBS, AT, and EM covered procedure codes provided in the FIS Waiver shall be reimbursed as a service limit of one. The maximum Medicaid funded expenditure per individual for all AT and EM covered procedure codes (combined total of AT and EM items and labor related to these items) shall be \$5,000 each for AT and \$5,000 for EM per calendar year. The maximum expenditure for EHBS shall be \$5,000 per calendar year. No additional provider mark-ups shall be permitted.

D. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, the Virginians with Disabilities Act, or any other applicable statute.

2. Payment for services under the ISP shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

3. Payment for services under the ISP shall not be made for services that are duplicative of each other.

4. Payments for services shall only be provided as set out in the individual's' ISP.

Part X
~~Intellectual Disability~~ Community Living (CL) Waiver

Article 1
 Definitions and General Requirements

12VAC30-120-1000. Definitions.

"AAIDD" means the American Association on Intellectual and Developmental Disabilities.

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

"ADA" means the Americans with Disabilities Act pursuant to 42 USC § 12101 et seq.

"Agency-directed model" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

~~"Applicant" means a person (or his representative acting on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to a home and community based waiver or is on the waiver waiting list waiting for a slot to become available.~~

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

"Barrier crime" means those crimes listed in §§ 32.1-162.9:1, 37.2-314, 37.2-416, 37.2-506, 37.2-607, and 63.2-1719 of the Code of Virginia.

~~"Behavioral health authority" or "BHA" means the local agency, established by a city or county under § 37.2-600 same as defined in § 37.2-600 of the Code of Virginia that plans, provides, and evaluates mental health, intellectual disability (ID), and substance abuse services in the locality that it serves.~~

"Behavioral specialist" means a person who possesses any of the following credentials: (i) endorsement by the Partnership for People with Disabilities at Virginia Commonwealth University as a positive behavioral supports facilitator; (ii) board certification as a behavior analyst (BCBA) or board certification as an associate behavior analyst (BCABA) as required by § 54.1-2957.16 of the Code

of Virginia; or (iii) licensure by the Commonwealth as either a psychologist, a licensed professional counselor (LPC), a licensed clinical social worker (LCSW), or a psychiatric clinical nurse specialist.

~~"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the Individual Support Plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the Individual Support Plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the Individual Support Plan.~~

~~"Case manager" means the person who provides case management services on behalf of the community services board or behavioral health authority, as either an employee or a contractor, possessing a combination of (ID) work experience and relevant education that indicates that the individual possesses the knowledge, skills, and abilities as established by DMAS in 12VAC30-50-450 delivers the support coordination/case management services set out in 12VAC30-50-455.~~

"Center-based crisis support services" means crisis prevention and stabilization in a crisis therapeutic home using planned and emergency admissions. They are designed for those individuals who need ongoing crisis supports.

"Centers for Medicare and Medicaid Services" or "CMS" means the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Challenging behavior" means culturally abnormal behaviors of such intensity, frequency, and duration that the physical safety of the individual or others is placed in serious jeopardy or that the behavior limits access to ordinary community facilities. These behaviors include withdrawal, self-injury, injury to others, aggression, or self-stimulation.

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

"Community-based crisis support services" means services to individuals who are experiencing crisis events putting them at risk for homelessness, incarceration, hospitalization, or danger to themselves or others. This service shall provide ongoing supports to individuals in their homes and in community settings.

"Community coaching" means a service designed for individuals who need one-to-one support in order to develop

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a specific skill to address barriers preventing that individual from participating in the community engagement services.

"Community engagement" means services that support and foster individuals' abilities 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.

"Community Living Waiver" or "CL Waiver" means the waiver set out in 12VAC30-120-1000 et seq.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, ID, and substance abuse services in the jurisdiction or jurisdictions it serves same as defined in § 37.2-100 of the Code of Virginia.

"Companion" means a person who provides companion services for compensation by DMAS.

"Companion services" means nonmedical care, support, and socialization provided to an adult (ages 18 years and over). The provision of companion services does not entail routine hands-on care. It is provided in accordance with a therapeutic outcome goal in the Individual Support Plan and is not purely diversional in nature.

"Complex behavioral needs" means conditions requiring exceptional supports in order to respond to the individual's significant safety risk to self or others and documented by the Supports Intensity Scale[®] (SIS[®]) Virginia Supplemental Risk Assessment form (2010) as described in 12VAC30-120-1012.

"Complex medical needs" means conditions requiring exceptional supports in order to respond to the individual's significant health or medical needs requiring frequent hands-on care and medical oversight and documented by the Supports Intensity Scale (SIS) Virginia Supplemental Risk Assessment form (2010) as described in 12VAC30-120-1012.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care information by the case manager and is used as a basis for the development of the Individual Support Plan.

~~"Congregate residential support" or "CRS" means those supports in which the residential support services provider renders primary care (room, board, general supervision) and residential support services to the individual in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home, (ii) in the home of the ID Waiver services provider (such as adult foster care or~~

~~sponsored residential), or (iii) in an apartment or other home setting.~~

~~"Consumer directed model" means a model of service delivery for which the individual or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of the person or persons who render the direct support or services reimbursed by DMAS~~

~~"Crisis stabilization" means direct intervention to individuals with ID who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.~~

"Consumer-directed attendant" or "CD attendant" means a person who provides via the consumer-directed model of services, person assistance services, companion services, or respite services, or any combination of these three services, and who is also exempt from workers' compensation.

"Consumer direction" means a model of service delivery for which the individual or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of the person or persons who render the direct support or services reimbursed by DMAS.

"Crisis support services" means intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention, and crisis stabilization to an individual who is experiencing an episodic behavioral or psychiatric event in the community that has the potential to jeopardize the current community living situation.

"DARS" means the Department for Aging and Rehabilitative Services.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DBHDS staff" means persons employed by or contracted with DBHDS.

"Developmental disability" or "DD" means the same as defined in § 37.2-100 of the Code of Virginia.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finder's fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the provider's services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, for example, monthly, quarterly, or annual giveaways as inducements to use the provider's services; or (vi) engaging in marketing activities that offer potential customers rebates or

discounts in conjunction with the use of the provider's services or other benefits as a means of influencing the individual's and the individual's family/caregivers use of the provider's services.

"Direct support professional" or "DSP" means staff members identified by the provider as having the primary role of assisting an individual on a day-to-day basis with routine personal care needs, social support, and physical assistance in a wide range of daily living activities so that the individual can lead a self-directed life in his own community.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by or contracted with DMAS.

~~"Day support" means services that promote skill building and provide supports (assistance) and safety supports for the acquisition, retention, or improvement of self help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his highest potential level of functioning.~~

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

~~"Direct marketing" means either (i) conducting directly or indirectly door to door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's and the individual's family/caregivers, as appropriate, use of the providers' services.~~

"DSS" means the Virginia Department of Social Services.

"Electronic home-based supports" or "EHBS" means goods and services based on current technology, such as Smart Home[®], and includes purchasing electronic devices, software, services, and supplies not otherwise covered through other benefits in the CL Waiver or through the State Plan for Medical Assistance that allows individuals to use technology in their residences to achieve greater independence and self-determination and reduce the need for human intervention.

~~"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer directed model of service delivery. The EOR may be the individual enrolled in the waiver, or a family member, a caregiver, or another designated person, as appropriate, when the individual is unable to perform the employer functions.~~

~~"Enroll" means that the individual has been determined by the case manager to meet the level of functioning requirements for the ID Waiver and DBHDS has verified the availability of an ID Waiver slot for that individual. Financial eligibility determinations and enrollment in Medicaid are set out in 12VAC30-120-1010 the same as defined in 12VAC30-120-501.~~

~~"Entrepreneurial model" means a small business employing a shift of eight or fewer individuals who have disabilities and usually involves interactions with the public and coworkers who do not have disabilities.~~

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

"EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 years according to federal guidelines (that prescribe preventive and treatment services for Medicaid eligible children) as defined in 12VAC30-50-130.

"ES service authorization" means the process of approving an individual, by either DMAS or its designated service authorization contractor, for the purpose of receiving exceptional supports. ES service authorization shall be obtained before exceptional supports to the individual are rendered.

"Exceptional reimbursement rate" or "exceptional rate" means a rate of reimbursement for congregate residential supports paid to providers who qualify to receive the exceptional rate set out in 12VAC30-120-1062.

"Exceptional supports" or "exceptional support services" means a qualifying level of supports, as more fully described in 12VAC30-120-1012, that are medically necessary for individuals with complex medical or behavioral needs, or both, to safely reside in a community setting. The need for exceptional supports is demonstrated when the funding required to meet the individual's needs has been expended on a consistent basis by providers in the past 90 days for medical or behavioral supports, or both, over and above the current maximum allowable CRS rate in order to support the individual in a manner that ensures his health and safety.

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"Face-to-face visit" means an in-person meeting between the support coordinator/case manager and individual, and family/caregiver, as appropriate, for the purpose of assessing the individual's status and determining satisfaction with services, including the need for additional services and supports.

"Fiscal employer/agent" means a state agency or other entity as determined by DMAS to meet the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act (Chapter 43 (§ 2.2-4300 et seq.) of Title 2.2 of the Code of Virginia).

"Freedom of choice" means the right afforded an individual who is determined to require a level of care specified in a waiver to choose (i) either institutional or home and community based services provided there are available CMS-allocated and state funded slots; (ii) providers of services; and (iii) waiver services as may be limited by medical necessity same as defined in § 1902(a)(23) of the Social Security Act.

"General supports" means staff presence to ensure that appropriate action is taken in an emergency or an unanticipated event and includes (i) awake staff during nighttime hours; (ii) routine bed checks; (iii) oversight of unstructured activities; (iv) asleep staff at night on premises for security or safety reasons, or both; or (v) on-call staff.

"Group day services" means services for the individual to acquire, retain, or improve skills of self-help, socialization, community integration, employability and adaptation via opportunities for peer interactions, community integration, and enhancement of social networks.

"Group home residential services" means skill-building, routine supports, general supports, and safety supports that are provided primarily in a licensed residence that enable the individual to acquire, retain, or improve skills necessary to successfully live in the community.

"Group supported employment services" means continuous support provided by staff in a naturally occurring place of employment to groups of two to eight individuals with developmental disabilities and involves interactions with the public and coworkers who do not have developmental disabilities.

~~"Health planning region" or "HPR" means the federally designated geographical area within which health care needs assessment and planning takes place, and within which health care resource development is reviewed.~~

"Health, safety, and welfare standard" means the standard that is applied when an individual who is enrolled in a DD waiver requests additional waiver services. It is the standard applied to ensure that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written, approved individual plan for supports, and that services can be safely provided in the community.

"Home and community-based waiver services" or "waiver services" means the range of community services approved

by the CMS, pursuant to § 1915(c) of the Social Security Act, to be offered to persons as an alternative to institutionalization.

~~"IDOLS" means Intellectual Disability Online System.~~

~~"In home residential support services" means support provided in a private residence by a DBHDS licensed residential provider to an individual enrolled in the waiver to include: (i) skill building and supports and safety supports to enable individuals to maintain or improve their health; (ii) developing skills in daily living; (iii) safely using community resources; (iv) being included in the life of the community and home; (v) developing relationships; and (vi) participating as citizens of the community. In home residential support services shall not replace the primary care provided to the individual by his family and caregiver but shall be supplemental to it.~~

"ICF/IID" means a facility or distinct part of a facility licensed by DBHDS and meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disabilities and individuals with related conditions and that addresses the total needs of the individuals, which include physical, intellectual, social, emotional, and habilitation, and provides active treatment as defined in 42 CFR 483.440.

"Incremental step-down provisions" means procedures normally found in plans for supports in which an individual's supports are gradually altered or reduced based upon progress towards meeting the goals of the individual's behavior plan.

~~"Individual" means the person receiving the services or evaluations established in this chapter the same as defined in 12VAC30-120-501.~~

"Individual supported employment" means one-on-one ongoing supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports to work in an integrated setting.

"Individual Support Plan" or "ISP" means a comprehensive, person-centered plan that sets out the supports and actions to be taken during the year by each service provider, as detailed in the each service provider's Plan for Supports, which are part of the ISP, to achieve desired outcomes. The Individual Support Plan shall be developed collaboratively by the individual enrolled in the waiver, the individual's family/caregiver, as appropriate, other service providers ~~such as the case manager, the support coordinator/case manager,~~ and other interested parties chosen by the individual; and shall contain the DMAS-approved ISP components essential information, what is important to the individual on a day-to-day basis and in the future, and what is important for the individual to be healthy and safe as reflected in the Plan for Supports. The Individual Support Plan is known as the Consumer Service Plan in the Day Support Waiver.

"In-home support services" means residential services that take place in the individual's home, family home, or community settings that typically supplement the primary care provided by the individual, family, or other unpaid caregiver and are designed to ensure the health, safety and welfare of the individual.

"Instrumental activities of daily living" or "IADLs" means tasks complex skills needed to successfully live independently such as meal preparation, shopping, housekeeping, laundry, and money management.

"Intellectual disability" or "ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) in the Intellectual Disability: Definition, Classification, and Systems of Supports (11th edition, 2010).

"ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Licensed practical nurse" or "LPN" means a person who is licensed or holds multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice practical nursing as defined in § 54.1-3000 of the Code of Virginia.

"LMHP" means a licensed mental health professional as defined in 12VAC35-105-20.

"LMHP-resident" means the same as defined in 12VAC30-50-130.

"LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee" means the same as defined in 12VAC30-50-130.

"Medicaid Long-Term Care Communication Form" or "DMAS-225" means the form used by the case support coordinator/case manager to report information about changes in an individual's situation.

"Medically necessary" means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practice as determined by DMAS and in accordance with Medicaid policy.

"Parent" or "parents" means a person or persons who is or are biologically or naturally related, a foster parent, or an adoptive parent to the individual enrolled in the waiver.

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for authorization of services until all required information is received by ~~DBHDS~~ DMAS or its designee.

"Person-centered planning" means a fundamental process that focuses on what is important to and for an individual and on the needs and preferences of the individual to create an Individual Support Plan that shall contain essential information, a personal profile, and desired outcomes of the individual to be accomplished through waiver services and included in the providers' Plans for Supports.

"Personal assistance services" means assistance direct support with ADLs, IADLs, access to the community, monitoring of self-administration of medication or other medical needs, and the monitoring of health status and physical condition or work or post-secondary school related personal assistance.

"Personal assistant" means a person who provides personal assistance services employed by a provider agency.

"Personal emergency response system" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization 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.

"Personal profile" means a point-in-time synopsis of what an individual enrolled in the waiver wants to maintain, change, or improve in his life and shall be completed by the individual and another person, such as his case manager support coordinator/case manager or family/caregiver, chosen by the individual to help him plan before the annual planning meeting where it is discussed and finalized.

"Plan for Supports" means each service provider's plan for supporting the individual enrolled in the waiver in achieving his desired outcomes and facilitating the individual's health and safety. The Plan for Supports is one component of the Individual Support Plan. The Plan for Supports is referred to as an Individual Service Plan in the Day Support and Individual and Family with Developmental Disability Services (IFDDS) Waivers.

"Prevocational services" means services aimed at preparing an individual enrolled in the waiver for paid or unpaid employment. The services do not include activities that are specifically job task oriented but focus on concepts such as accepting supervision, attendance at work, task completion, problem solving, and safety. Compensation for the individual, if provided, shall be less than 50% of the minimum wage.

"Positive behavior support" means an applied science that uses educational methods to expand an individual's behavior repertoire and systems, change methods to redesign an individual's living environment to enhance the individual's quality of life, and minimize his challenging behaviors.

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"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support ~~of~~ without compensation for such care to the individual enrolled in the waiver to enable him to live successfully in the community without compensation for providing such care.

"Private duty nursing services" means individual and continuous nursing care to individuals that may be provided, concurrently with other services, due to the medical nature of supports required by individuals who have a serious medical condition or complex health care needs, or both, and that has been certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital, nursing facility, or ICF/IID.

"Progressive condition" means disease or health condition that gets worse over time, resulting in general decline in health or function, including aging.

"Qualified developmental disabilities professional" or "QDDP" means a professional who (i) possesses at least one year of documented experience working directly with individuals who have developmental disabilities; (ii) is one of the following: a doctor of medicine or osteopathy, a registered nurse, a provider holding at least a bachelor's degree in a human service field including, but not limited to, sociology, social work, special education, rehabilitation engineering, counseling, or psychology, or a provider who has documented equivalent qualifications; and (iii) possesses the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

~~"Qualified mental retardation professional" or "QMRP" for the purposes of the ID Waiver means the same as defined at 12VAC35-105-20.~~

"Qualifying individual" means an individual who has received an ES service authorization from DMAS or its service authorization contractor to receive exceptional supports.

"Registered nurse" or "RN" means a person who is licensed or holds multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice professional nursing.

~~"Residential support services" means support provided in the individual's home by a DBHDS licensed residential provider or a VDSS-approved provider of adult foster care services. This service is one in which skill building, supports, and safety supports are routinely provided to enable individuals to maintain or improve their health, to develop skills in daily living and safely use community resources, to be included in the community and home, to develop relationships, and to participate as citizens in the community.~~

~~"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care temporary,~~

substitute care that is normally provided by the family or other unpaid, primary caregiver who resides in the same home as the individual. Services shall be provided on a short-term basis due to the emergency absence of or need for routine or periodic relief of the primary caregiver.

"Review committee" means DBHDS staff, including a trained SIS[®] specialist approved by DBHDS, a behavior specialist, a registered nurse, and a master's level social worker, and other staff as may be otherwise constituted by DBHDS, who will evaluate and make a determination about applications for the congregate residential support services and CRS exceptional reimbursement rate for compliance with regulatory requirements.

"Risk assessment" means an assessment that is completed by the ~~case manager support coordinator/case manager~~ to determine areas of high risk of danger to the individual or others based on the individual's serious medical or behavioral factors. The required risk assessment for ~~the ID Waiver~~ each waiver shall be found in the state-designated assessment form which may be supplemented with other information. The risk assessment shall be used to plan risk mitigating supports for the individual in the Individual Support Plan.

"Routine supports" means supports that assist the individual with daily activities.

"Safety supports" means specialized assistance that is required to ~~assure the health and welfare of an individual~~ ensure an individual's health and safety.

~~"Service authorization" means the process approving by either DMAS or its designated service authorization contractor, for the purpose of DMAS' reimbursement, the service for the individual before it is rendered.~~

"Service authorization" means the process to approve specific services for an enrolled Medicaid individual by a DMAS service authorization designee prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS requirements for reimbursement. Service authorization does not guarantee payment for the service.

"Services facilitation" means a service that assists the individual ~~or the individual's family/caregiver~~, or EOR, as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery.

~~"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual or the individual's family/caregiver, or EOR, as appropriate, by collaborating with the case manager to ensure the development and monitoring of the CD Services Plan for Supports, providing employee management training, and completing ongoing review activities as required by DMAS for consumer directed companion, personal assistance, and respite services.~~

"Services facilitator" means a DMAS-enrolled provider or DMAS-designated entity or one who is employed by or contracts with a DMAS-enrolled services facilitator, who is responsible for supporting the individual or EOR, as appropriate, by ensuring the development and monitoring of the Plan for Supports for consumer-directed model of services, providing employee management training, and completing ongoing review activities as required by the DMAS-approved consumer-directed model of services. "Services facilitator" shall be deemed to mean the same thing as "consumer-directed services facilitator."

"Shared living" means an arrangement in which a roommate resides in the same household as the individual receiving waiver services and provides an agreed-upon, limited amount of supports. In exchange for providing the agreed-upon support, a portion of the total cost of rent, food, and utilities that can be reasonably attributed to the live-in roommate is reimbursed to the individual.

"Significant change" means, but shall not be limited to, includes a change in an individual's condition that is expected to last longer than 30 calendar days but shall not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclical pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Skill building supports" means those supports that help the individual gain new skills and abilities and was previously called training.

"Skilled nursing services" means both skilled and hands on care, as rendered by either a licensed RN or LPN, of either a supportive or health related nature and may include, but shall not be limited to, all skilled nursing care as ordered by the attending physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual enrolled in the waiver nursing services (i) listed in the plan of care that do not meet home health criteria, (ii) required to prevent institutionalization, (iii) not otherwise available under the State Plan for Medical Assistance, (iv) provided within the scope of § 54.1-3000 et seq. of the Code of Virginia and the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), and (v) provided by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state. Skilled nursing services are to be used to provide training, consultation, nurse delegation as appropriate, and oversight of direct care staff as appropriate.

"Slot" means an opening or vacancy in waiver services for an individual.

"Sponsored residential services" means residential services that consist of skill-building, routine supports, general supports, and safety supports provided in the homes of

families or persons (sponsors) providing supports under the supervision of a DBHDS-licensed provider that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Support coordination/case management" means the same as defined in 12VAC30-50-455 D.

"Support coordinator/case manager" means the person who provides support coordination/case management services to an individual in accordance with 12VAC30-50-455.

"Supports" means paid and nonpaid assistance that promotes the accomplishment of an individual's desired outcomes. There shall be ~~three~~ four types of supports: (i) routine supports that assist the individual in daily activities; (ii) skill building supports ~~that~~ to help the individual gain new abilities; ~~and~~ (iii) safety supports that are required to assure the individual's health and safety; and (iv) general supports that provide general oversight.

~~"Supported employment" means paid supports provided in work settings in which persons without disabilities are typically employed. Paid supports include skill building supports related to paid employment, ongoing or intermittent routine supports, and safety supports to enable an individual with ID to maintain paid employment.~~

"Supported living residential services" means a service taking place in an apartment setting operated by a DBHDS-licensed provider that consist of skill-building, routine supports, general supports, and safety supports that enable the individual to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to successfully live in home and community settings.

~~"Support plan" means the report of recommendations resulting from a therapeutic consultation.~~

~~"Supports Intensity Scale®" or "SIS®" means a tool, developed by the American Association on Intellectual and Developmental Disabilities that measures the intensity of an individual's support needs for the purpose of assessment, planning, and aligning resources to enhance personal independence and productivity the same as defined in 12VAC30-120-501.~~

~~"Therapeutic consultation" means covered services designed to assist the individual and the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver professional consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic~~

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recreation, physical therapy, or behavior consultation disciplines that are designed to assist individuals, parents, family members, and any other providers of support services with implementing the Individual Support Plan.

"Therapeutic consultation plan" means the report of recommendations resulting from a therapeutic consultation.

"Transition services" means set-up expenses the same as defined in 12VAC30-120-2010.

"VDSS" means the Virginia Department of Social Services.

"Workplace assistance services" means supports provided to an individual who has completed job development and has completed or nearly completed job placement training (i.e., supported employment) but requires more than typical job coach services to maintain stabilization in their employment.

12VAC30-120-1005. Waiver ~~description and legal authority~~ service population and provider requirements.

~~A. Home and community based waiver services shall be available through a § 1915(c) waiver of the Social Security Act. Under this waiver, DMAS has waived § 1902(a) (10) (B) and (C) of the Social Security Act related to comparability of services. These services shall be appropriate and necessary to maintain the individual in the community.~~

~~B. Federal waiver requirements, as established in § 1915 of the Social Security Act and 42 CFR 430.25, provide that the average per capita fiscal year expenditures in the aggregate under this waiver shall not exceed the average per capita expenditures for the level of care provided in an ICF/ID, as defined in 42 CFR 435.1010 and 42 CFR 483.440, under the State Plan that would have been provided had the waiver not been granted.~~

~~C. DMAS shall be the single state agency authority pursuant to 42 CFR 431.10 responsible for the processing and payment of claims for the services covered in this waiver and for obtaining federal financial participation from CMS. The Department of Behavioral Health and Developmental Services (DBHDS) shall be responsible for the daily administrative supervision of the ID Waiver in accordance with the interagency agreement between DMAS and DBHDS.~~

~~D. Any of the services covered under the authority of this waiver shall be required in order for the individual to avoid institutionalization.~~

~~E. A. Waiver service populations. These waiver services shall be provided for the following individuals who have been determined to require the level of care provided in an ICF/ID ICF/IID:~~

~~1. Individuals with ID; ~~or~~ DD.~~

~~2. Individuals younger than the age of six who are at developmental risk. At the age of six years, these individuals must have a diagnosis of ID to continue to receive these home and community based waiver services.~~

~~Individuals enrolled in the waiver who attain the age of six years of age, who are determined not to have a diagnosis of~~

~~ID, and who meet all Individual and Family Developmental Disability Support (IFDDS) Waiver eligibility criteria, shall be eligible to apply for transfer to the IFDDS Waiver for the period of time up to their seventh birthday. Psychological evaluations or standardized development assessments confirming individuals' diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These individuals transferring from the ID Waiver will be assigned a slot in the IFDDS Waiver, if one is available. The case manager shall submit the current Level of Functioning Survey, Individual Support Plan, and psychological evaluation (or standardized developmental assessment for children under six years of age) to DMAS for review. Upon determination by DMAS that the individual is appropriate for transfer to the IFDDS Waiver and there is a slot available for the child, the ID case manager shall provide the family with a list of IFDDS Waiver case managers. The ID case manager shall work with the selected IFDDS Waiver case manager to determine an appropriate transfer date and shall submit a DMAS 225 to the local department of social services. The ID Waiver slot shall be held by the CSB until the child has successfully transitioned to the IFDDS Waiver. Once the child's transition into the IFDDS Waiver is complete, the CSB shall reallocate the ID slot to another individual on the waiting list.~~

~~F. ID services shall not be offered or provided to an individual who resides outside of the physical boundaries of the United States or the Commonwealth. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, ICF/ID, or inpatient rehabilitation facility. Individuals with ID who are inpatients of these facilities may receive case management services as described in 12VAC30-50-450. The case manager may recommend waiver services that would promote exiting from the institutional placement; however, these waiver services shall not be provided until the individual has exited the institution.~~

~~G. An individual shall not be simultaneously enrolled in more than one waiver.~~

~~H. DMAS shall be responsible for assuring appropriate placement of the individual in home and community based waiver services and shall have the authority to terminate such services for the individual who no longer qualifies for the waiver. Termination from this waiver shall occur when the individual's health and medical needs can no longer be safely met by waiver services in the community.~~

~~I. No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed.~~

~~B. Core competency requirements for direct support professionals (DSPs) and their supervisors in programs licensed by DBHDS shall be the same as those set forth in 12VAC30-120-515 A.~~

~~C. Core competency requirements for support coordinators/case managers. (Reserved.)~~

D. Core competency requirements for QDDPs. (Reserved.)

E. Advanced core competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs as identified by assignment to levels 5, 6, or 7 shall be the same as those set forth in 12VAC30-120-515 D.

F. Provider enrollment requirements shall be the same as those set forth in 12VAC30-120-514.

G. Documentation requirements shall be the same as those set forth in 12VAC30-120-514 Q.

H. Reevaluation of service need requirements shall be the same as those set forth in 12VAC30-120-515 F.

I. Utilization review requirements shall be the same as those set forth in 12VAC30-120-515 G.

12VAC30-120-1010. Individual eligibility requirements. (Repealed.)

~~A. Individuals receiving services under this waiver must meet the following Medicaid eligibility requirements. The Commonwealth shall apply the financial eligibility criteria contained in the State Plan for the categorically needy. The Commonwealth covers the optional categorically needy groups under 42 CFR 435.211, 42 CFR 435.217, and 42 CFR 435.230.~~

~~1. The income level used for 42 CFR 435.211, 42 CFR 435.217 and 42 CFR 435.230 shall be 300% of the current Supplemental Security Income (SSI) payment standard for one person.~~

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

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

~~a. For individuals to whom § 1924(d) applies and for whom the Commonwealth waives the requirement for~~

~~comparability pursuant to § 1902(a)(10)(B), DMAS shall deduct the following in the respective order:~~

~~(1) The basic maintenance needs for an individual under this waiver, which shall be equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.~~

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

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

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

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

~~(1) The basic maintenance needs for an individual under this waiver, which is equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% 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~~

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~~allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.~~

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

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

B. ~~The following four criteria shall apply to all individuals who have ID who seek these waiver services:~~

~~1. Individuals qualifying for ID Waiver services shall have a demonstrated need for the service due to significant functional limitations in major life activities. The need for these waiver services shall arise from either (i) an individual having a diagnosed condition of ID or (ii) a child younger than six years of age being at developmental risk of significant functional limitations in major life activities;~~

~~2. Individuals qualifying for ID Waiver services shall meet the ICF/ID level of care criteria;~~

~~3. The Individual Support Plan and services that are delivered shall be consistent with the Medicaid definition of each service; and~~

~~4. Services shall be recommended by the case manager based on his documentation of the need for each specific service as reflected in a current assessment using a DBHDS approved SIS instrument, or for children younger than five years of age, an alternative industry assessment instrument, such as the Early Learning Assessment Profile, and authorized by DBHDS.~~

C. ~~Assessment and enrollment.~~

~~1. To ensure that Virginia's home and community based waiver programs serve only individuals who would otherwise be placed in an ICF/ID, home and community-based waiver services shall be considered only for individuals who are eligible for admission to an ICF/ID due to their diagnoses of ID, or individuals who are younger than six years of age and who are at developmental risk. For the case manager to make a recommendation for waiver services, ID Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/ID, or to promote exiting from an ICF/ID or other institutional placement.~~

~~2. The case manager shall recommend the individual for home and community based waiver services after determining diagnostic and functional eligibility. This~~

~~determination shall be mandatory before DMAS assumes payment responsibility of home and community based waiver services and shall include:~~

~~a. The required level of care determination by applying the existing DMAS ICF/ID criteria (Part VI (12VAC30-130 430 et seq.) of the Amount, Duration and Scope of Selected Services Regulation) to be completed no more than six months prior to enrollment. The case manager determines whether the individual meets the ICF/ID criteria with input from the individual and the individual's family/caregiver, as appropriate, and service and support providers involved in the individual's support; and~~

~~b. A psychological evaluation or standardized developmental assessment for children who are younger than six years of age that reflects the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of the individual's functioning.~~

~~3. The case manager shall provide the individual and the individual's family/caregiver, as appropriate, with the choice of ID Waiver services or ICF/ID placement.~~

~~4. The case manager shall enroll the individual in the ID Waiver or, if no slot is available, place the individual on the waiting list. The CSB shall only enroll the individual following electronic confirmation by DBHDS that a slot is available. If no slot is available, then the individual's name shall be placed on either the urgent or nonurgent statewide waiting list, consistent with criteria established in this waiver in 12VAC30 120 1088, until such time as a slot becomes available. Once the individual's name has been placed on either the urgent or nonurgent waiting list, the case manager shall notify the individual in writing within 10 business days of his placement on either list and offer appeal rights. The case manager shall contact the individual and the individual's family/caregiver, as appropriate, at least annually while the individual is on the waiting list to provide the choice between institutional placement and waiver services.~~

D. ~~Waiver approval process: authorizing and accessing services.~~

~~1. Once the case manager has determined an individual meets the functional criteria for ID Waiver services, has determined that a slot is available, and that the individual has chosen ID Waiver services, the case manager shall submit enrollment information via the IDOLS to DBHDS to confirm level of care eligibility.~~

~~2. Once the individual has been enrolled by the CSB, the case manager will submit a DMAS 225 along with a computer generated confirmation of level of care eligibility to the local department of social services to determine financial eligibility for the waiver program and any patient pay responsibilities.~~

3. After the case manager has received written notification of Medicaid eligibility by the local departments of social services, the case manager shall so inform the individual and the individual's family/caregiver, as appropriate, to permit the development of the Individual Support Plan.

a. The individual and the individual's family/caregiver, as appropriate, shall meet with the case manager within 30 calendar days of waiver enrollment to discuss the individual's needs and existing supports, complete the DBHDS approved assessment, obtain a medical examination completed no earlier than 12 months prior to the initiation of waiver services, begin to develop the Personal Profile, and complete all designated assessments, such as the Supports Intensity Scale (SIS), deemed necessary to establish and document the needed services.

b. The case manager shall provide the individual and the individual's family/caregiver, as appropriate, with choice of needed services available under the ID Waiver, alternative settings, and providers. Once the service providers are chosen, a planning meeting shall be arranged by the case manager to develop the person-centered Individual Support Plan based on the assessment of needs as reflected in the level of care and DBHDS approved functional assessment instruments and the preferences of the individual and the individual's family/caregiver's, as appropriate.

c. Participants invited to participate in the person-centered planning meeting shall include the individual, case manager, service providers, the individual's family/caregiver, as appropriate, and others desired by the individual. The Individual Support Plan development process identifies the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered. The individual enrolled in the waiver, or the family/caregiver as appropriate, and case manager must sign the ISP.

4. The individual or case manager shall contact chosen service providers so that services can be initiated within 30 calendar days of enrollment. The service providers in conjunction with the individual and the individual's family/caregiver, as appropriate, and the case manager shall develop Plans for Supports for each service. A copy of these plans shall be submitted to the case manager. The case manager shall review and ensure the Plan for Supports meets the established service criteria for the identified needs prior to submitting to the state designated agency or its contractor for service authorization. Only ID Waiver services authorized on the Individual Support Plan by the state designated agency or its contractor according to DMAS policies may be reimbursed by DMAS. The Plan for Supports from each waiver service provider shall be incorporated into the Individual Support Plan along with

the steps for risk mitigation as indicated by the risk assessment.

5. When the case manager obtains the DMAS 225 form from a local department of social services, the case manager shall designate and inform in writing a service provider to be the collector of patient pay when applicable. The designated provider shall monthly monitor the DMAS-designated system for changes in patient pay obligations and adjust billing, as appropriate, with the change documented in the record in accordance with DMAS policy. When the designated collector of patient pay is the consumer directed personal or respite assistant or companion, the case manager shall forward a copy of the DMAS 225 form to the EOR along with the case manager's designation described in 12VAC30-120-1060 S 2 a (6). In such cases, the case manager shall be required to perform the monthly monitoring of the patient pay system and shall notify the EOR of all changes.

6. The case manager shall submit the results of the comprehensive assessment and a recommendation to DBHDS staff for final determination of ICF/ID level of care and authorization for community-based services. The state designated agency or its contractor shall, within 10 working days of receiving all supporting documentation, review and approve, pend for more information, or deny the individual service requests. The state designated agency or its contractor shall communicate in writing to the case manager whether the recommended services have been approved and the amounts and type of services authorized or if any services have been denied. Medicaid shall not pay for any home and community based waiver services delivered prior to the authorization date approved by the state designated agency or its contractor if service authorization is required.

7. ID Waiver services may be recommended by the case manager only if:

a. The individual is Medicaid eligible as determined by the local departments of social services;

b. The individual has a diagnosis of ID as defined by the American Association on Intellectual and Developmental Disabilities, or is a child under the age of six at developmental risk, and who would in the absence of waiver services require the level of care provided in an ICF/ID the cost of which would be reimbursed under the Plan; and

c. The contents of the Plans for Support are consistent with the Medicaid definition of each service.

8. All Individual Support Plans shall be subject to final approval by DMAS. DMAS is the single state agency authority responsible for the supervision of the administration of the ID Waiver.

9. If services are not initiated by the provider within 30 days of receipt of enrollment confirmation from DBHDS,

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the case manager shall notify the local department of social services so that a re-evaluation of eligibility as a noninstitutionalized individual can be made.

10. In the case of an individual enrolled in the waiver being referred back to a local department of social services for a redetermination of eligibility and in order to retain the designated slot, the case manager shall submit information to DBHDS via IDOLS requesting retention of the designated slot pending the initiation of services. A copy of the request shall be provided to the individual and the individual's family/caregiver, as appropriate. DBHDS shall have the authority to approve the slot retention request in 30 day extensions, up to a maximum of four consecutive extensions, or deny such request to retain the waiver slot for that individual. DBHDS shall provide a response to the case manager via IDOLS indicating denial or approval of the slot extension request. DBHDS shall submit this response within 10 working days of the receipt of the request for extension and include the individual's right to appeal its decision.

E. Reevaluation of service need.

1. The Individual Support Plan.

a. The Individual Support Plan, as defined herein, shall be collaboratively developed annually by the case manager with the individual and the individual's family/caregiver, as appropriate, other service providers, consultants, and other interested parties based on relevant, current assessment data.

b. The case manager shall be responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the Individual Support Plan as indicated by the changing needs of the individual. At a minimum, the case manager must review the Individual Support Plan every three months to determine whether the individual's desired outcomes and support activities are being met and whether any modifications to the Individual Support Plan are necessary.

c. Any modification to the amount or type of services in the Individual Support Plan shall be prior authorized by the state designated agency or its contractor.

d. All requests for increased waiver services by individuals enrolled in the waiver shall be reviewed under the health, safety, and welfare standard and for consistency with cost effectiveness. This standard assures that an individual's ability to receive a waiver service is dependent on the finding that the individual needs the service, based on appropriate assessment criteria and a written Plan for Supports, and that services can safely and cost effectively be provided in the community.

2. Review of level of care.

a. The case manager shall complete a reassessment annually in coordination with the individual and the individual's family/caregiver, as appropriate, and service

providers. The reassessment shall include an update of the level of care and Personal Profile, risk assessment, and any other appropriate assessment information. The Individual Support Plan shall be revised as appropriate.

b. At least every three years for those individuals who are 16 years of age and older and every two years for those individuals who are ages birth through 15 years old, or when the individual's support needs change significantly, the case manager, with the assistance of the individual and other appropriate parties who have knowledge of the individual's circumstances and needs for support, shall complete the DBHDS approved SIS form or an approved alternative instrument for children younger than the age of five years.

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

d. A new psychological evaluation shall be required whenever the individual's functioning has undergone significant change (such as a loss of abilities or awareness that is expected to last longer than 30 days) and is no longer reflective of the past psychological evaluation. A psychological evaluation or standardized developmental assessment for children younger than six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities.

3. The case manager shall monitor the service providers' Plans for Supports to ensure that all providers are working toward the desired outcomes of the individuals.

4. Case managers shall be required to conduct monthly onsite visits for all individuals enrolled in the waiver residing in VDSS licensed assisted living facilities or approved adult foster care homes. Case managers shall conduct a minimum of quarterly onsite home visits to individuals receiving ID Waiver services who reside in DBHDS licensed sponsored residential homes.

12VAC30-120-1019. (Reserved.)

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

A. Covered services in the ~~ID~~ CL Waiver include: assistive technology, center-based crisis supports services, community-based crisis support services, community coaching, community engagement, companion services (both consumer-directed and agency-directed), crisis stabilization, day support, crisis support services, electronic home-based supports (EHBS), environmental modifications, group day services, group home residential services, group supported employment, individual supported employment, in-home

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

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

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

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

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

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

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

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

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

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

~~the change of services from consumer directed to agency directed.~~

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

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

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

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

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

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

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

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

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

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

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

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

~~1. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for equipment or~~

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modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. AT shall be covered in the least expensive, most cost effective manner.

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

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

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

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

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

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

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

C. Companion (both consumer directed and agency directed) services. Service description. These services provide nonmedical care, socialization, or support to an adult (age 18 or older). Companions may assist or support the individual enrolled in the waiver with such tasks as meal preparation, community access and activities, laundry, and shopping, but

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

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

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

3. Service units and service limitations.

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

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

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

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

D. Crisis stabilization. Service description. These services shall involve direct interventions that provide temporary intensive services and support that avert emergency psychiatric hospitalization or institutional placement of individuals with ID who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services shall

have two components: (i) intervention and (ii) supervision. Crisis stabilization services shall include, as appropriate, neuropsychiatric, psychiatric, psychological, and other assessments and stabilization techniques, medication management and monitoring, behavior assessment and positive behavioral support, and intensive service coordination with other agencies and providers. This service shall be designed to stabilize the individual and strengthen the current living situation, so that the individual remains in the community during and beyond the crisis period.

1. These services shall be provided to:

- a. Assist with planning and delivery of services and supports to enable the individual to remain in the community;
- b. Train family/caregivers and service providers in positive behavioral supports to maintain the individual in the community; and
- c. Provide temporary crisis supervision to ensure the safety of the individual and others.

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

- a. Meet at least one of the following: (i) the individual shall be experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) the individual shall be experiencing an increase in extreme emotional distress; (iii) the individual shall need continuous intervention to maintain stability; or (iv) the individual shall be causing harm to himself or others; and
- b. Be at risk of at least one of the following: (i) psychiatric hospitalization; (ii) emergency ICF/ID placement; (iii) immediate threat of loss of a community service due to a severe situational reaction; or (iv) causing harm to self or others.

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

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

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

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

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

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

4. Crisis supervision shall be an optional component of crisis stabilization in which one to one supervision of the individual who is in crisis shall be provided by agency staff in order to ensure the safety of the individual and others in the environment. Crisis supervision may be provided as a component of crisis stabilization only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided one to one and face to face with the individual. Crisis supervision, if provided as a part of this service, shall be separately billed in hourly service units.

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

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

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

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

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

3. Levels of day support. There shall be two levels of day support, intensive and regular. To be authorized at the intensive level, the individual shall meet at least one of the following criteria: (i) the individual requires physical assistance to meet the basic personal care needs (such as but not limited to toileting, eating/feeding); (ii) the individual requires additional, ongoing support to fully

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participate in programming and to accomplish the individual's desired outcomes due to extensive disability-related difficulties; or (iii) the individual requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral support activities shall be required to address behaviors such as, but not limited to, withdrawal, self injury, aggression, or self stimulation. Individuals not meeting these specified criteria for intensive day support shall be provided with regular day support.

4. Service units and service limitations.

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

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

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

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

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

F. Environmental modifications (EM). Service description. This service shall be defined, as set out in 12VAC30-120-1000, as those physical adaptations to the individual's primary home, primary vehicle, or work site that shall be required by the individual's Individual Support Plan, that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence. Environmental modifications reimbursed by DMAS may only be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act. Such adaptations may include, but shall not necessarily be limited to, the installation of ramps and grab bars, widening of doorways, modification

of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual. Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long term support to the individual and is not a paid provider of services.

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

2. Service units and service limitations.

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

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

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

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

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

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

f. Excluded from coverage under this waiver service shall be those adaptations or improvements to the home that are of general utility and that are not of direct medical or remedial benefit to the individual enrolled in the waiver, such as, but not necessarily limited to, carpeting, roof repairs, and central air conditioning. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation

Act. Adaptations that add to the total square footage of the home shall be excluded from this service. Except when EM services are furnished in the individual's own home, such services shall not be provided to individuals who receive residential support services.

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

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

- a. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
- b. Purchase or lease of a vehicle; and
- c. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications that were covered under this waiver benefit.

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

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

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

3. Service units and service limitations.

- a. The unit of service shall be one hour.

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

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

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

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

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

2. Service units and service limitations.

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

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

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

I. Prevocational services. Service description. These services shall be intended to prepare an individual enrolled in the waiver for paid or unpaid employment but shall not be job-task oriented. Prevocational services shall be provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver

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services. Activities included in this service shall not be directed at teaching specific job skills but at underlying habilitative outcomes such as accepting supervision, regular job attendance, task completion, problem solving, and safety. There shall be two levels of this covered service: (i) intensive and (ii) regular.

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

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

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

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

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

3. There shall be documentation regarding whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for

services through the IDEA due to his age, documentation shall be required only for lack of DRS funding. When these services are provided through these alternative funding sources, the Plan for Supports shall not authorize prevocational services as waiver expenditures.

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

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

1. Criteria.

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

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

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

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

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

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

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

- a. This service shall be provided on an individual-specific basis according to the Plan for Supports and service setting requirements;
- b. Congregate residential support shall not be provided to any individual enrolled in the waiver who receives personal assistance services under the ID-Waiver or other residential services that provide a comparable level of care. Residential support services shall be permitted to be provided to the individual enrolled in the waiver in conjunction with respite services for unpaid caregivers;
- c. Room, board, and general supervision shall not be components of this service;
- d. This service shall not be used solely to provide routine or emergency respite care for the family/caregiver with whom the individual lives; and
- e. Medicaid reimbursement shall be available only for residential support services provided when the individual is present and when an enrolled Medicaid provider is providing the services.

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

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

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

unpaid caregiver or caregivers who normally provide care for the individual.

3. Criteria:

- a. In order to qualify for respite services, the individual shall demonstrate a need for assistance with ADLs, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.
- b. Respite services shall only be offered to individuals who have an unpaid primary caregiver or caregivers who require temporary relief. Such need for relief may be either episodic, intermittent, or periodic.

4. Service units and service limitations:

- a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per individual per state fiscal year. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency directed and CD models shall not exceed 480 hours per year combined.
- b. Each individual, family, or caregiver shall have a back-up plan for the individual's care in case the respite assistant does not report for work as expected or terminates employment without prior notice.
- c. Respite services shall not be provided to relieve staff of either group homes, pursuant to 12VAC35-105-20, or assisted living facilities, pursuant to 22VAC40-72-10, where residential supports are provided in shifts. Respite services shall not be provided for DMAS reimbursement by adult foster care providers for an individual residing in that foster home.
- d. Skill development shall not be provided with respite services.
- e. The hours to be authorized shall be based on the individual's need. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the respite assistant.

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

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

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covered for an individual absent one of these consumer directed services.

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

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

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

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

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

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

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

~~5. A face to face meeting shall occur between the services facilitator and the individual at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual. During these visits with the individual, the services facilitator shall observe, evaluate, and consult with~~

~~the individual, EOR, and the individual's family/caregiver, as appropriate, for the purpose of documenting the adequacy and appropriateness of CD services with regard to the individual's current functioning and cognitive status, medical needs, and social needs. The services facilitator's written summary of the visit shall include, but shall not necessarily be limited to:~~

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

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

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

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

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

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

~~g. Any other services received and the amount.~~

~~6. The services facilitator, during routine visits, shall also review and verify timesheets as needed to ensure that the number of hours approved in the Plan for Supports is not exceeded. If discrepancies are identified, the services facilitator shall discuss these with the individual or the EOR to resolve discrepancies and shall notify the fiscal/employer agent. If an individual is consistently identified as having discrepancies in his timesheets, the services facilitator shall contact the case manager to resolve the situation.~~

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

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

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

~~10. If an individual enrolled in consumer directed services has a lapse in services facilitator duties for more than 90 consecutive days, and the individual or family/caregiver is not willing or able to assume the service facilitation duties, then the case manager shall notify DMAS or its designated prior authorization contractor and the consumer directed services shall be discontinued once the required 10 days~~

notice of this change has been observed. The individual whose consumer directed services have been discontinued shall have the right to appeal this discontinuation action pursuant to 12VAC30-110. The individual shall be given his choice of an agency for the alternative personal care, respite, or companion services that he was previously obtaining through consumer direction.

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

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

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

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

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

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

e. Specific employer duties shall include checking references of assistants, determining that assistants meet specified qualifications, timely and accurate completion of hiring packets, training the assistants, supervising assistants' performance, and submitting complete and accurate timesheets to the fiscal/employer agent on a consistent and timely basis.

M. Skilled nursing services. Service description. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled nursing services

may be provided in the individual's home or other community setting on a regularly scheduled or intermittent basis. It may include consultation, nurse delegation as appropriate, oversight of direct support staff as appropriate, and training for other providers.

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

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

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

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

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

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

b. Group supported employment shall be defined as continuous support provided by staff to eight or fewer

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individuals with disabilities who work in an enclave, work crew, bench work, or in an entrepreneurial model.

3. Criteria.

a. Only job development tasks that specifically pertain to the individual shall be allowable activities under the ID Waiver supported employment service and DMAS shall cover this service only after determining that this service is not available from DRS for this individual enrolled in the waiver.

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

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

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

4. Service units and service limitations.

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

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

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

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

O. Therapeutic consultation. Service description. This service shall provide expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual enrolled in the waiver. The specialty areas shall be (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services shall be based on the individuals' Individual Support Plans, and shall be provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their abilities to

function in the community. Therapeutic consultation services may be provided in individuals' homes, and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to facilitate implementation of individuals' desired outcomes as identified in their Individual Support Plans.

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

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

b. Therapeutic consultation services shall not include direct therapy provided to individuals enrolled in the waiver and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.

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

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

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

12VAC30-120-1021. Covered services: assistive technology in FIS, CL, and BI Waivers.

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

including the ancillary supplies and equipment necessary to the proper functioning of such items.

1. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for equipment for remedial or direct medical benefit primarily in the individual's primary home, primary 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. The equipment and activities shall include:

- a. Specialized medical equipment, ancillary equipment, and supplies necessary for life support;
- b. Durable or nondurable medical equipment and supplies that are not otherwise available through the State Plan for Medical Assistance;
- c. Adaptive devices, appliances, and controls which enable an individual to be independent in areas of personal care and ADLs; and
- d. Equipment and devices which enable an individual to communicate more effectively.

2. Service units and service limitations. AT shall be available to individuals who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting described above in subdivision A 1 of this subsection. Only the AT services set out in the ISP shall be covered by DMAS. AT shall be service authorized by the state-designated agency or its designee for each calendar year with no carry-over of unspent funds across calendar years.

- a. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be \$5,000 per calendar year. The service unit shall always be one for the total cost of all AT being requested for a specific timeframe.
- b. AT shall not be approved for purposes of convenience of the caregiver or restraint of the individual.

3. Service requirements.

- a. An independent professional consultation to determine the level of need that is not performed by the AT provider shall be obtained from staff knowledgeable of that item for each AT request prior to approval by the state-designated agency or its designee. Equipment, supplies, or technology not available as durable medical equipment through the State Plan for Medical Assistance may be purchased and billed as AT as long as the request for such equipment, supplies, or technology is documented and justified in the individual's ISP, recommended by the support coordinator/case manager, service authorized by the state-designated agency or its designee, and provided in the least expensive, most cost-effective manner possible.

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

c. The AT provider shall obtain, install, and demonstrate, as necessary, such service authorized 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.

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

e. Requests for AT services shall be denied if waiver services are available for children under EPSDT (12VAC30-50-130). No duplication of payment for AT services shall be permitted between the waiver and services covered for adults that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

4. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1061 A and B.

B. Benefits planning. (Reserved.)

12VAC30-120-1022. Covered services: community engagement; community coaching.

A. Community engagement service description.

1. Community engagement means services that support and foster an individual's abilities to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choices 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 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. This service shall be provided in the least restrictive and most integrated settings possible according to the individual's Plan for Supports and individual choice. Community engagement is a tiered service for reimbursement purposes.

2. Community engagement criteria. Individuals who are authorized for community engagement shall have a Plan for Supports.

3. Community engagement allowable activities include:

- a. Skill building, education, support and monitoring that assists the individual with the acquisition and retention of

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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 therapeutic 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.

4. Community engagement service units and service limits. Service authorization shall be required.

a. The unit of service shall be one hour.

b. Community engagement services alone or in combination with group day, community coaching, workplace assistance services, or supported employment services shall not exceed 66 hours per week.

c. This service shall be delivered in the community and shall not take place in a licensed residential setting nor in the individual's residence.

d. This service shall be provided at a ratio of no more than one staff to three individuals.

e. Community engagement may include planning community activities with the individual, although this shall be limited to no more than 10% of the total number of authorized hours per month.

f. Providers shall only be reimbursed for the tier to which the individual has been assigned based on the individual's assessed needs.

5. Community engagement provider requirements.

a. Community engagement providers shall be licensed by DBHDS as a provider of day support services.

b. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1065 A.

B. Community coaching.

1. Community coaching service description. Community coaching means services that are designed for individuals who need one to one support in a variety of community settings in order to build a specific skill or set of skills to address a particular barrier or barriers preventing an individual from participating in activities of community engagement. In addition to skill building, this service includes safety supports.

2. Community coaching criteria. This service may be provided to individuals who require one to one support to address identified barriers in their Plan for Supports that prevent them from participating in the community engagement service.

3. Community coaching allowable activities.

a. Individuals who are authorized for community coaching shall have a Plan for Supports. Community coaching activities and supports shall be contained in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences.

b. One-on-one skill-building and coaching to facilitate participation in community activities and opportunities such as (i) activities and public events in the community; (ii) community education, activities, and events; and (iii) use of public transportation.

c. Skill building and support in positive behavior, relationship building, and social skills.

d. Support with the individual's self-management, eating, and personal care needs in the community.

4. Community coaching service units and service limits.

a. The unit of service shall be one hour.

b. Community coaching, alone or in combination with community engagement, group day, workplace assistance services, or supported employment services shall not exceed 66 hours per week.

c. This service shall be provided at a ratio of no more than one staff to one individual.

d. Community coaching cannot be provided prior to service authorization.

5. Community coaching provider requirements.

a. Community coaching providers shall be licensed by DBHDS as a provider of day support services.

b. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1065 B.

C. Community guide services. (Reserved.)

12VAC30-120-1023. Covered services: companion (agency-directed and consumer-directed).

A. Service description.

1. This service provides nonmedical care, socialization, or general support to adults (18 years of age or older). These services shall be provided in either the individual's home or

at various locations in the community. It may be coupled with residential support services as needed.

2. Companions may assist or support the individual enrolled in the waiver with IADLs (including meal preparation, community access and activities, laundry, and shopping) but companions do not perform these activities as discrete services. Companions may also perform light housekeeping tasks (including bed-making, dusting and vacuuming, grocery shopping) when such services are specified in the individual's Plan for Supports and essential to the individual's health and welfare in the context of providing nonmedical care, socialization, or support, as may be needed in order to maintain the individual's home environment in an orderly and clean manner. Companions shall provide safety supports.

3. Companion services shall be provided in accordance with the ISP to meet an assessed need of the individual and shall not be purely recreational in nature.

4. This service may be provided and reimbursed either through an agency-directed or a consumer-directed model.

a. Consumer direction involves hiring, training, supervising, and terminating persons serving as companions by either the individual in the waiver or the EOR.

b. Individuals choosing to receive companion services through the consumer-directed model may choose a services facilitator to provide the training and ongoing guidance necessary to be the employer.

c. An individual who is unable to independently manage his own consumer-directed companion services may designate an adult family member/caregiver or some other person who agrees to fulfill the required duties to serve as the employer of record on behalf of the individual.

B. Criteria.

1. In order to qualify for companion services, the individual enrolled in the waiver shall have demonstrated a need for assistance with IADLs, community access, reminders for medication self-administration, or support to ensure his safety.

2. Individuals choosing the consumer-directed option shall meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

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

2. A companion shall not be permitted to provide nursing care procedures including care of ventilators, tube feedings, suctioning of airways, external catheters, or

wound care. A companion shall not provide routine support with ADLs.

3. The hours that may be authorized shall be based on documented individual need. No more than two unrelated individuals who are receiving waiver services and who live in the same home shall be permitted to share the authorized work hours of the companion. Providers shall not bill for more than one individual at the same time.

4. Companion services shall not be provided by adult foster care providers or any other paid caregivers for an individual residing in that foster care home.

D. Provider requirements for companion services shall be the same as those set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1059.

12VAC30-120-1024. Covered services: crisis support services (such as prevention, intervention, stabilization); center-based crisis supports; community-based crisis supports.

A. Service description.

1. Crisis support services shall provide intensive supports to an individual who has a history of or is experiencing an episodic behavioral or psychiatric crisis in the community. These services are designed to prevent the individual from experiencing an episodic crisis that has the potential to jeopardize his current community living situation, to intervene in such a crisis, or to stabilize the individual after the crisis. This service shall prevent escalation of a crisis, maintain safety, stabilize the individual and strengthen the current living situation, so the individual can be supported in the community beyond the crisis period. Crisis support services may include as appropriate and necessary:

a. 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 initiation of positive behavior supports to resolve and prevent future occurrence of crisis situations. Crisis prevention shall also encompass supporting the family and individual through team meetings, revising the behavior plan or guidelines, and other activities as changes to the behavior support plan are implemented and residual concerns from the crisis situation are addressed.

b. Crisis intervention services shall be used during a crisis to prevent further escalation of the situation and to maintain the immediate personal safety of those involved. This shall be a short-term service providing highly structured intervention that can include, for example, temporary changes to the person's residence, changes to the person's daily routine, and emergency referral to other care providers.

c. 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 the

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individual or others. Crisis stabilization services shall be 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.

2. Center-based crisis support means planned crisis prevention and emergency crisis stabilization services in a crisis therapeutic home using planned and emergency admissions. They are designed for those individuals who will need ongoing crisis supports. Planned admissions shall be provided to individuals receiving crisis services and who need temporary, therapeutic interventions outside of their home setting to maintain stability. Emergency admissions shall be provided to individuals who are experiencing an identified behavioral health need or behavior challenge that is preventing them from reaching stability within their home settings.

3. Community-based crisis supports means services to individuals experiencing crisis events that put them at risk for homelessness, incarceration, hospitalization, or danger to self or others. This service shall provide ongoing supports to individuals in their homes and other community settings. These services provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be maintained during and beyond the crisis period.

B. Criteria.

1. Crisis support services are designed for individuals experiencing circumstances such as (i) marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) an increase in emotional distress; (iii) needing continuous intervention to maintain stability; or (iv) causing harm to themselves or others.

2. Center-based crisis supports are designed for individuals with a history of at least one of the following: (i) psychiatric hospitalization or hospitalizations; (ii) incarceration; (iii) residential/day placement or placements that were terminated; or (iv) behavior or behaviors that have significantly jeopardized placement. In addition, the individual shall meet at least one of the following: (i) is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) is experiencing an increase in emotional distress; (iii) needs continuous intervention to maintain stability; or (iv) is causing harm to themselves or others. The individual shall also (i) be at risk of psychiatric hospitalization; (ii) be at risk of emergency ICF/IID placement; (iii) be at immediate risk of loss of community service due to severe situational reaction; or (iv) be actually causing harm to themselves or others.

3. Community-based crisis supports are ongoing supports to the individual who may have (i) a history of multiple

psychiatric hospitalizations, frequent medication changes, or setting changes or (ii) a history of requiring enhanced staffing due to his mental health or behavioral issues. They are designed for those individuals who will need ongoing crisis supports. In order to be approved to receive this service, the individual shall have a history of at least one of the following: (i) previous psychiatric hospitalization or hospitalizations; (ii) previous incarceration; (iii) residential/day placement or placements that were terminated; or (iv) behavior or behaviors that have significantly jeopardized placement. In addition, the individual shall meet at least one of the following: (i) is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) is experiencing an increase in extreme emotional distress; (iii) needs continuous intervention to maintain stability; or (iv) is actually causing harm to himself or others. The individual shall also (i) be at risk of psychiatric hospitalization; (ii) be at risk of emergency ICF/IID placement; (iii) be at immediate threat of loss of community service due to a severe situational reaction; or (iv) be actually causing harm to himself or others.

C. Allowable activities.

1. Crisis support services prevention allowable activities.

a. The crisis support provider shall train and mentor staff or family members who support the individual long term once the crisis has stabilized in order to minimize or prevent recurrence of the crisis. Crisis support staff shall deliver support in such a way that maintains the individual's typical routine to the maximum extent possible.

b. Crisis prevention entails ongoing assessment of an individual's medical, cognitive, and behavioral status including predictors of self-injurious, disruptive, or destructive behaviors with use of positive behavior supports. This service shall also include providing training to family/caregivers to avert further crises and to maintain the individual's typical routine to the maximum extent possible.

c. Crisis stabilization entails gaining a full understanding of the factors that contributed to the crisis once the immediate threat has resolved. These services result in the development of new plans that may include environmental modifications, interventions to enhance communication skills, or changes to the individual's daily routine or structure. Crisis stabilization staff shall train family/caregivers and other persons significant to the individual in techniques and interventions to avert future crises.

2. Crisis support services intervention allowable activities. Crisis support staff providing crisis intervention shall model verbal de-escalation techniques including active listening, reflective listening, validation and suggestions for immediate changes to the situation.

3. Center-based crisis supports allowable activities include: (i) a variety of types of face-to-face assessments (psychiatric, neuropsychiatric, psychological, behavioral) and stabilization techniques; (ii) medication management and monitoring; (iii) behavior assessment and positive behavior support; (iv) intensive care coordination with other agencies or providers to maintain the individual's community placement; (v) training family members/caregivers and service providers in positive behavior supports; (vi) skill building related to the behavior creating the crisis such as self-care/ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance; and (vii) supervising the individual in crisis to ensure his safety and that of other persons in the environment.

4. Community-based crisis supports allowable activities shall be provided in either the individual's home or in community settings, or both. Crisis staff shall work directly with the individual, his current support provider and his family/caregiver, or both. Services are provided using (i) coaching; (ii) teaching; (iii) modeling; (iv) role-playing; (v) problem solving; or (vi) direct assistance. Activities include: (i) psychiatric, neuropsychiatric psychological, and behavioral assessments and stabilization techniques; (ii) medication management and monitoring; (iii) behavior assessment and positive behavior support; (iv) intensive care coordination with agencies or providers to maintain the individual's community placement; (v) family/caregiver training in positive behavioral supports to maintain the individual in the community; (vi) skill building related to the behavior creating the crisis such as self-care/ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance; and (vii) supervision to ensure the individual's safety and the safety of others in the environment.

D. Service units and service limitations.

1. Crisis support services shall be authorized or re-authorized following a documented face-to-face assessment conducted by a QDDP.

a. Crisis prevention. The unit of the service shall be one hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis prevention may be authorized for up to 60 days per ISP year. Crisis prevention services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

b. Crisis intervention. The unit of the service shall be one hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year. Crisis intervention services include supports during the provision of any

other waiver service and may be billed concurrently (same dates and times).

c. Crisis stabilization. The unit of the service shall be one hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year. Crisis stabilization services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

2. Center-based crisis supports shall be limited to six months per ISP year and shall be authorized in increments of up to a maximum of 30 days with each authorization. Center-based crisis supports shall not be provided during the provision of the following waiver services and shall not be billed concurrently (same dates and times): group home residential, sponsored residential, supported living, or agency directed or consumer-directed respite.

3. Community-based crisis supports is an hourly service unit and may be authorized for up to 24 hours per day if necessary in increments of no more than 15 days at a time. The annual limit is 1080 hours. Requests for additional community-based crisis supports services in excess of the 1080-hour annual limit will be considered if justification of medical necessity is provided.

E. Provider requirements. In addition to the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-501 et seq. and 12VAC30-120-1063, the following provider requirements apply:

1. Providers of all crisis support services, center-based crisis support services, community-based crisis support services shall have current signed participation agreements with DMAS and shall directly provide the services and bill DMAS for Medicaid reimbursement. These providers shall renew their participation agreements as directed by DMAS.

2. Crisis support services shall be provided by entities licensed by DBHDS as providers of outpatient crisis stabilization services, residential crisis stabilization services, or nonresidential crisis stabilization services. Providers shall employ or utilize QDDPs, licensed mental health professionals, or other qualified personnel licensed to provide clinical or behavioral interventions.

3. Center-based crisis support providers shall be licensed by DBHDS as providers of group home residential services and either emergency services or residential crisis stabilization services. Center-based crisis supports shall be provided by a licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, certified pre-screener, QDDP, or DSP under the supervision of one of the professionals listed in this subsection.

4. Community-based crisis support providers shall be licensed by DBHDS as providers of emergency services,

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outpatient crisis stabilization services, residential crisis stabilization services or nonresidential crisis stabilization services. Community-based crisis support services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a certified pre-screener, or QDDP.

5. Provider documentation requirements.

a. Supporting documentation shall be developed (or revised, in the case of a request for an extension) and submitted to the support coordinator/case manager for authorization within 72 hours of the face-to-face assessment or reassessment.

b. Documentation indicating the dates and times of crisis services, the amount and type of service provided, and specific information about the individual's response to the services and supports in the supporting documentation shall be recorded in the individual's record.

c. Documentation of provider qualifications shall be maintained for review by DMAS or DBHDS staff and shall be provided upon request from either agency.

12VAC30-120-1025. Covered services: electronic home-based supports (EHBS); environmental modifications (EM).

A. Electronic home-based supports (EHBS).

1. Service description. This service shall provide devices, equipment, or supplies, based on current technology, such as Smart Home© technology, to enable the individual to live in his community and participate in his community more safely while decreasing the need for other services such as staff supports. The equipment or devices shall be purchased for the individual and shall be typically installed in the individual's home. Portable hand-held devices may be used by the individual at home or in the community. These devices and services shall support the individual's greater independence and self-reliance in the community. This service may also include ongoing electronic monitoring, which is the provision of oversight and monitoring within the home through off-site monitoring.

2. Criteria.

a. In order to qualify for this service, the individual shall be at least 18 years of age and shall be physically capable of using the equipment provided via this service.

b. A preliminary needs assessment shall be completed by a technology specialist to determine the best type and use of technology and overall cost effectiveness of various options. This assessment shall be submitted to the DMAS designee for service authorization prior to the delivery of any goods and services and prior to the submission of any claims for Medicaid reimbursement. The technology specialist conducting the preliminary assessment may be an occupational therapist, or other similarly credentialed specialist, who is licensed or certified by the Commonwealth and specializes in assistive technologies,

mobile technologies, and current accommodations for individuals with developmental disabilities.

c. The service shall support training in the use of these goods and services, ongoing maintenance, and monitoring services to address an identified need in the individual's ISP, including improving and maintaining the individual's opportunities for full participation in the community.

d. Items or services purchased through EBHS shall be designed to decrease the need for other Medicaid services (such as reliance on staff supports); promote inclusion in the community; or increase the individual's safety in the home environment.

3. Service units and limits.

a. The annual ISP year limit for this service shall be \$5,000. No unspent funds from one plan year shall be accumulated and carried over to subsequent plan years.

b. Receipt of this service shall not be tied to the receipt of any other covered waiver or Medicaid services. Equipment or supplies already covered by any other Medicaid covered service shall be excluded from coverage by this waiver service. This service shall not be covered for individuals who are receiving residential supports that are reimbursed on a daily basis, such as group home, or sponsored or supported living residential services.

4. Provider requirements.

a. An EHBS provider shall be one of the following: (i) a Medicaid-enrolled personal care agency; (ii) a Medicaid-enrolled durable medical equipment provider; (iii) a CSB; (iv) a center for independent living; (v) a licensed and Medicaid-enrolled home health provider; or (vi) a PERS manufacturer that is Medicaid-enrolled and has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring services.

b. The provider of ongoing monitoring systems shall 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.

c. 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.

d. The EHBS provider shall properly install all equipment and shall furnish all supplies necessary to ensure that the system is installed and working properly.

e. 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. The provider responsible for installation of devices shall document the date of installation and training in their use.

f. The provider of off-site monitoring shall document each instance of action being taken on behalf of the individual. This documentation shall be maintained in this provider's record for the individual and shall be provided to either DMAS or DBHDS upon demand.

g. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1061.

B. Environmental modifications (EM).

1. Service description. This service shall be defined as set out in 12VAC30-120-1000. Adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems 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.

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

3. Service units and service limitations.

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

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

c. EM shall be available to individuals enrolled in the waiver who are receiving at least one other waiver service. EM shall be service authorized by the state-designated agency or its designee for each calendar year

with no carry-over of authorized unspent funds across calendar years.

d. Providers of EM services shall not be the spouse or parents (natural, adoptive, or foster parents) or legal guardians of the individual enrolled in the waiver.

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

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

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

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

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

(1) Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;

(2) Purchase or lease of a vehicle; and

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

4. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1061. If a provider has previously made environmental modifications, that previous work shall have been completed satisfactorily in order to be authorized for future jobs. These providers shall perform all servicing and repairs that the modification may require for the individual's successful use.

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12VAC30-120-1026. Covered services: group day services.

Group day services.

1. Service description. Group day services means services for the individual to acquire, retain, or improve skills of self-help, socialization, community integration, career planning and adaptation via opportunities for peer interactions, community integration, and enhancement of social networks. These services shall be typically offered in a nonresidential setting. Supports may be provided for the purpose of Medicaid reimbursement. Skill building shall be a component of this service unless the individual has a documented progressive condition in which case group day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Group day services is a tiered service for reimbursement purposes. Providers shall only be reimbursed for the individual's assigned level and tier.

2. Criteria. For group day services, an individual shall demonstrate the need for skill-building or supports offered primarily in settings other than the individual's own residence that allows him an opportunity for being a productive and contributing member of his community. In addition, group day services shall be available for individuals who can benefit from supported employment services, but who need these services as an appropriate alternative or in addition to supported employment services.

3. Allowable activities shall include, as may be appropriate for the individual as documented in his Plan for Supports:

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.

4. Service units and service limitations.

a. This service unit shall be one hour. Group day services, alone or in combination with (but not at the same time as) community engagement, community coaching, workplace assistance, or supported

employment services, shall not exceed 66 hours per week. Group day services occur one or more hours per day on a regularly scheduled basis for one or more days per week in settings that are separate from the individual's home.

b. Group day services shall be billed according to the DMAS fee schedule.

c. Group day staffing ratios shall be based on the activity and the individual's needs as set out in his Plan for Supports and shall be limited to a ratio of a maximum of one staff to seven individuals.

d. Service providers shall be reimbursed only for the amount of group day services that are rendered as established in the individual's approved Plan for Supports based on the setting, intensity, and duration of the service to be delivered.

5. Provider Requirements. Documentation shall confirm the individual's attendance and the amount of the individual's time in services and provide specific information regarding the individual's response to various settings and supports. Observation of the individual's responses to the services shall be available in a daily progress note.

a. The provider shall review the supporting documentation with the individual or his family/caregiver, as appropriate, and submit a written summary of this review to the support coordinator/case manager at least quarterly with the Plan for Supports modified as appropriate. For the annual review and anytime the supporting documentation is updated, the supporting documentation shall be reviewed with the individual or his family/caregiver, as appropriate, and such review shall be documented.

b. An attendance log or similar document shall be maintained that indicates the date, type of services rendered, and the number of hours and units provided, including specific timeframe.

c. In instances where group day services staff are required to ride with the individual to and from group day service, the group day service staff time may be billed as group day service, provided that the billing for this time does not exceed 25% of the total time the individual spent in the group day service activity for that day. Documentation shall be maintained to verify that billing for group day service staff coverage during transportation does not exceed 25% of the total time spent in the group day service for that day.

d. Supervision of direct service staff shall be provided by a qualified developmental disabilities professional.

e. Providers shall ensure that individuals providing group day services meet provider competency training requirements as specified in 12VAC30-120-1005.

f. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq.

12VAC30-120-1027. Covered services: group home residential services.

A. Service description. Group home residential services shall consist of skill-building, routine supports, general supports, and safety supports that are provided to enable an individual to acquire, retain, or improve skills necessary to successfully live the community. These services shall be provided to individuals who are living in (i) a group home or (ii) the home of an adult foster care provider, and services shall be provided in a licensed or foster care approved residence. Group home residential is a tiered service for reimbursement purposes (as described in 12VAC30-120-570) based on the individual's assigned level and tier and licensed bed capacity of the home. Group home residential services shall be provided to the individual as continuous services up to 24 hours per day performed by paid staff who shall be physically present with the individual. These supports may be provided either individually or simultaneously to more than one individual living in that home, depending on the required support. Providers shall only be reimbursed for the individual's assigned level and tier and based on the licensed bed capacity of the group home.

B. Criteria. Only individuals who are on the CL Waiver shall be eligible for group home residential services.

C. Allowable activities. The allowable activities shall include, as may be appropriate for the individual as documented in his Plan for Supports:

1. Skill-building and providing routine supports related to ADLs and IADLs;
2. Skill-building and providing routine supports and safety supports related to the use of community resources (transportation, shopping, restaurant dining, and participating in social and recreational activities). The cost of participation in the actual social or recreational activity shall not be reimbursed;
3. Supporting the individual in replacing challenging behaviors with positive, accepted behavior for home and community environments;
4. Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;
5. Providing routine supports and safety supports with transportation to and from training sites and community resources;
6. Providing general supports, as needed; and
7. Providing safety supports to ensure the individual's health and safety.

D. Service units and limitations.

1. The unit of service shall be a day.

2. Group home residential services shall be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports. These services shall be service authorized.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq., and 12VAC30-120-1064.

12VAC30-120-1028. Covered services: in-home support services.

A. In-home support service description. In-home support services means residential services that take place in the individual's home, family home, or community settings that typically supplement the primary care provided by the individual, family, or other unpaid caregiver and are designed to ensure the health, safety and welfare of the individual. This service shall consist of skill-building and routine supports, general supports, and safety supports that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. In-home support services require the presence of a skills development (formerly called training) component, along with the provision of supports. In-home support services is not a tiered service but shall be reimbursed according to the number of individuals served.

B. Criteria. To be eligible for in-home support services, individuals shall:

1. Be enrolled in the FIS or CL Waiver, and
2. Be living in their own home or family home.

C. Units and limits. The unit shall be one hour. These services shall not typically be provided 24 hours per day but may be authorized for brief periods up to 24 hours a day when medically necessary. This service shall not be covered for the individual simultaneously with the coverage of group home residential, supported living residential, or sponsored residential services. Individuals may have in-home supports, personal assistance, and respite services in their ISP but shall not receive these Medicaid-reimbursed services simultaneously.

D. Allowable activities include:

1. Skill-building and providing routine supports and safety supports related to personal care activities (ADLs);
2. Skill-building and providing routine supports and safety supports related to the use of community resources (transportation, shopping, dining at restaurants, and participating in social and recreational activities);
3. Supporting the individual in replacing challenging behaviors with positive, accepted behaviors for home and community environments;
4. Monitoring the individual's health and physical condition and providing general supports and safety supports with medication or other medical needs;

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5. Providing supports with ADLs and IADLs and using community resources;

6. Providing supports with transportation to and from training sites and community resources; or

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

E. Provider requirements.

1. All providers of this service shall have current, signed participation agreements with DMAS. The provider designated in this agreement shall directly submit claims to DMAS for reimbursement.

2. Provider documentation shall confirm the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the plan for supports. Data shall be collected as described in the Plan for Supports and summarized, and then necessary changes shall be added to the supporting documentation. Provider documentation shall be available in a daily progress note.

3. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and written summary of this review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.

4. Providers of in-home support services shall be licensed by DBHDS as providers of supportive in-home services.

5. The individual shall have a back-up plan for times when in-home supports cannot occur as regularly scheduled.

12VAC30-120-1029. Covered services: nonmedical transportation; personal assistance services (agency-directed and consumer-directed).

A. Nonmedical transportation activities. (Reserved.)

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

1. Personal assistance services means direct support with ADLs, IADLs, access to the community, monitoring of self-administration of medication or other medical needs, and the monitoring of health status and physical condition or work or postsecondary school-related personal assistance. Personal assistance services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function.

2. When specified in the Plan for Supports, personal assistance services may include assistance with IADLs. Assistance with IADLs shall be documented in the Plan for Supports as essential to the health and welfare of the individual, rather than for the individual's family/caregiver's comfort.

3. An additional component to personal assistance is work or postsecondary school-related personal assistance that

allows the personal assistance provider to provide assistance and supports to individuals in the workplace and postsecondary educational institutions. Work or postsecondary school-related personal assistance shall not be provided if they are services that should be provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal assistance services shall not duplicate services provided under supported employment.

C. Personal assistance services criteria.

1. In order to qualify for personal assistance services, the individual shall demonstrate a need for assistance with activities of daily living, reminders to take medication, or other medical needs, or monitoring health status or physical condition.

2. Individuals choosing the consumer-directed option for personal assistance services may receive support from a services facilitator and shall meet requirements for consumer direction as described in 12VAC30-120-759 and 12VAC30-120-770.

3. For personal assistance services, allowable activities include (i) support with ADLs; (ii) support with monitoring of health status or physical condition; (iii) support with prescribed use of medication and other medical needs; (iv) support with preparation and eating of meals; (v) support with housekeeping (such as bedmaking, cleaning, individual's laundry) activities; (vi) support with participation in social, recreational, and community activities; (vii) assistance with bowel/bladder care needs, range of motion activities, nonsterile technique routine wound care, and external catheters when supervised by an RN; (ix) accompanying the individual to appointments or meetings; and (x) safety supports.

D. Service units and service limitations.

1. The unit of service for personal assistance services shall be one hour. The hours to be authorized shall be based on the individual's assessed and documented need as reflected in the Plan for Supports.

2. Individuals may receive a combination of personal assistance, respite, and in-home support services as documented in their Plan for Supports but shall not receive in-home supports services and personal assistance or respite services at the same time.

3. The provider of personal assistance shall have a back-up plan in case the personal assistant or consumer-directed employee does not report for work as expected or terminates employment without prior notice.

4. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.

5. Individuals shall be permitted to share personal assistance service hours with one other individual (receiving waiver services) who lives in the same home.

6. This service does not include skilled nursing (neither practical nor professional nursing) services with the exception of skilled nursing tasks that are delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the personal assistant.

7. Services may be provided for Medicaid reimbursement by the individual's relative or legal guardian. Services shall not be reimbursed by Medicaid when they are provided by the individual's spouse or, if the individual is a minor child, by his parent or parents (natural, adoptive, foster, or step-parent).

8. Personal assistance shall not be reimbursed by DMAS for individuals who receive group home residential services, sponsored residential services, or supported living residential services, who live in assisted living facilities, or who receive comparable services from another program or service.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1059.

12VAC30-120-1030. ~~[Reserved]~~ Covered services: personal emergency response systems.

Personal emergency response system (PERS).

1. Service description. PERS is an electronic device and monitoring service that enables certain individuals at risk of institutionalization 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 supervision.

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

3. Service units and service limitations.

a. The one-time installation of the unit shall include installation, account activation, individual and caregiver instruction, and removal of PERS equipment. A unit of service is the one-month rental price set by DMAS.

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

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

d. Physician-ordered medication monitoring units shall be provided simultaneously with PERS services.

e. PERS shall not be covered for individuals who are simultaneously receiving group home residential services, sponsored residential services, or supported living residential services.

4. Provider requirements. Providers shall meet all requirements of 12VAC30-120-501 et seq., 12VAC30-120-1061 A and E, and subdivision 16 of 12VAC30-120-1560.

12VAC30-120-1031. Covered services: skilled nursing and private duty nursing.

A. Skilled nursing services.

1. Services description. This service shall provide part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services that cannot be provided by non-nursing personnel.

2. Services criteria. The individuals who are authorized to receive this service shall require specific skilled nursing services that cannot be provided by non-nursing personnel as documented in the Plan for Supports. This service shall be rendered to the individual in his residence or other community settings on a regularly scheduled or intermittent basis in accordance with the Plan for Supports.

3. Allowable activities shall be ordered and certified as medically necessary by a Virginia-licensed physician. The ordered services may include:

a. Consultation, assistance to direct support staff, and nurse delegation;

b. Training of family and other caregivers;

c. Monitoring an individual's medical status;

d. Administering medications and other medical treatment; or

e. Assurance that all items listed in subdivisions 3 a through 3 d of this subsection are carried out in accordance with the Individual Support Plan.

4. Service units and limits.

a. Skilled nursing services shall be ordered by a physician and shall be medically necessary.

b. This service shall be rendered and billed in quarter hour increments. Individuals receiving this service shall not be required to meet the criteria for the receipt of home health services. Skilled nursing services shall not be limited by the acute, time-limited standards for home

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health services as contained in the State Plan for Medical Assistance.

c. Individuals enrolled in the waiver shall not be authorized to receive waiver skilled nursing services concurrently with private duty nursing services or personal assistance services. Waiver skilled nursing services shall not be authorized or covered if the necessary service is available under EPSDT for an individual who is a child.

d. Foster care providers shall not be the skilled nursing services providers for the same individuals for whom they provide foster care.

e. The support coordinator/case manager shall assist an individual who has short-term, acute, and limited-in-nature skilled nursing needs in accessing the home health services benefit under the State Plan for Medical Assistance. Such short-term State Plan for Medical Assistance services shall be accessed from a licensed home health services provider that is a DMAS-enrolled provider.

f. The support coordinator/case manager shall assist an individual who has skilled nursing needs that are expected to be longer term, but intermittent in nature, with accessing skilled nursing services.

g. Skilled nursing services providers shall not be reimbursed while the individual enrolled in the waiver is receiving care in an emergency room or is receiving inpatient services in either an acute care hospital, nursing facility, rehabilitation facility, ICF/IID, or any other type of facility, or during emergency transport of the individual to such facilities.

5. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq., and 12VAC30-120-1067 A.

B. Private duty nursing services.

1. Service description. Private duty nursing services means individual and continuous nursing care that may be provided, concurrently with other services, due to the medical nature of supports required by individuals who have a serious medical condition or complex health care needs, or both, and that has been certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital, nursing facility, or ICF/IID. This service shall be rendered to the individual in his residence or other community settings.

2. Criteria.

a. The individual shall require these services as certified by a Virginia-licensed physician as medically necessary to enable the individual to remain at home or otherwise in the community rather than in a hospital, nursing facility, an ICF/IID, or any other type of institution.

b. The medical need for these services shall be documented in the individual's ISP. Once the medical need no longer exists, this service shall be terminated.

c. Individuals enrolled in the waiver shall not be authorized to receive private duty nursing services concurrently with skilled nursing services.

3. Allowable activities.

a. Monitoring of an individual's medical status;

b. Administering medications or other medical treatment.

4. Service units and limits.

a. Private duty nursing services shall be ordered by a Virginia-licensed physician and shall be medically necessary.

b. The unit of service shall be a quarter hour.

5. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1067 B.

12VAC30-120-1032. Covered services: respite (agency-directed; consumer-directed).

A. Respite services. Respite services may be provided either through an agency-directed or consumer-directed (CD) model. Refer to 12VAC30-120-759 and 12VAC30-120-770 for consumer-directed requirements.

B. Service description.

1. Respite services are temporary, substitute care that is normally provided by the family or other unpaid, primary caregiver who resides in the same home as the individual. Services shall be provided on a short-term basis due to the emergency absence of or need for routine or periodic relief of the primary caregiver.

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

C. Criteria.

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

2. The need for respite services shall be documented in the Plan for Supports.

D. Allowable activities shall include: (i) assistance with ADLs and IADLs; (ii) support with monitoring health status and physical condition; (iii) support with medication and medical needs; (iv) safety supports; (v) support to participate in social, recreational, or community activities; (vi) accompanying the individual to appointments or meetings; and (vii) assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when trained and supervised by an RN.

E. Service units and service limitations.

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

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

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

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

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

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

F. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1059.

12VAC30-120-1033. Covered services: services facilitation; consumer-directed model.

A. Services facilitation and consumer-directed service model.

B. Service description. The requirements for services facilitation shall be the same as those set forth in 12VAC30-120-759 and 12VAC30-120-770.

12VAC30-120-1034. Covered services: shared living.Shared living.

1. Service description. Shared living means Medicaid coverage of a portion of the total cost of rent, food, and utilities that can be reasonably attributed to a roommate who has no legal responsibility to financially support the individual who is enrolled in the waiver. The types of assistance provided are expected to vary from individual to individual and may include (i) fellowship, (ii) safety supports, and (iii) limited ADL/IADL help. This service shall require the use of an administrative provider that shall be responsible for directly coordinating the services and directly billing DMAS for reimbursement.

2. Criteria.

a. The individual, who shall be at least 18 years of age, shall select his roommate and, together through a planning process, they shall determine the assistance to be provided by the roommate based on the individual's needs and preferences. The individual shall reside in his own home or in a residence leased by the individual. Reimbursable room and board for the roommate shall be established through the service authorization process per the CMS-approved rate methodology, published on the DBHDS website.

b. The individual shall be receiving at least one other waiver service in order to receive Medicaid coverage of shared living.

3. Allowable activities include help with ADLs/IADLs, which shall account for no more than 20% of the anticipated roommate time and may include (i) help with meal preparation, light housework, and reminders to take medications and (ii) routine prompting or intermittent direct assistance with ADLs.

4. Covered services units and limits. The unit of service shall be a month or may be a partial month for months in which the service begins or ends.

a. The roommate shall 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 Virginia.

b. The roommate shall successfully meet the training requirements set out in the ISP including CPR training, safety awareness, fire safety and disaster planning, and conflict management and resolution.

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c. Shared living services shall not be covered for individuals who are simultaneously receiving group home residential, sponsored residential services, or supported living residential services.

d. The roommate shall not have the responsibility for providing skill-building or medical services. The roommate shall not be the spouse; parent, (biological, adoptive, foster, or step-parent); or legal guardian of the individual.

5. Provider requirements. Shared living administrative providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq., 12VAC30-120-1069, and subdivision 17 of 12VAC30-120-1560.

12VAC30-120-1035. Covered services: supported employment services.

A. Supported employment services. Service description. This service may be performed for a single individual (as in individual supported employment) or in small groups (as in group supported employment) of individuals (two to eight individuals). These services shall consist of ongoing supports that enable individuals to be employed in an integrated work setting and may include assisting the individual, either as a sole individual or in small groups, to locate a job or develop a job on behalf of the individual, as well as activities needed to sustain paid work by the individual or individuals including skill-building supports and safety supports on a job site.

1. These services shall be provided in work settings where persons without disabilities are employed. Supported employment services shall be especially designed for individuals with developmental disabilities who face impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential (i.e., the individual's ability to perform work).

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

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

a. Individual supported employment shall be defined as one-on-one ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, to work in an integrated setting. The outcome of this service shall be 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. For this service, reimbursement of supported employment shall be limited to actual documented interventions or

collateral contacts by the provider as required by the individual receiving waiver services but not for the supervisory activities rendered as a normal part of the regular business setting, and not the amount of time the individual enrolled in the waiver is in the supported employment situation.

b. Group supported employment shall be defined as continuous support provided by staff in a naturally occurring place of employment to groups of two to eight individuals with disabilities and involves interactions with the public and coworkers who do not have disabilities. This service shall be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community.

B. Criteria.

1. Only job development tasks that specifically pertain to the individual shall be allowable activities under the waiver-supported employment service and DMAS shall cover this service only after determining that this service is not available from DARS for the individual enrolled in the waiver.

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

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

C. Allowable activities for both individual and group supported employment include the following job development tasks, supports, and training. The individual shall be present unless otherwise noted below.

1. Vocational/job-related discovery or assessment;

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

3. Individualized job development, with or without the individual present, that produces an appropriate job match for the individual and the employer to include job analysis or determining job tasks, or both (this element is for individual supported employment only and is not permitted for group supported employment);

4. Negotiation with prospective employers, with or without the individual present;

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 ensure job retention, with or without the individual present;

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 or lunch areas and transportation systems; and

10. Staff provision of transportation between the individual's place of residence and the workplace when other forms of transportation are unavailable or inaccessible. The job coach shall be present with the individual during the provision of transportation.

D. Service units and service limitations.

1. Service providers shall be reimbursed only for the amount and type of supported employment included in the individual's ISP. The unit of service for individual supported employment shall be one hour and the service shall be limited to 40 hours per week per individual. The unit of service for group supported employment shall be one hour and the service shall be limited to 40 hours per week per individual.

2. Group supported employment is based on the size of the group. Individual supported employment shall be billed according to the DARS fee schedule.

3. Supported employment services alone or in combination with community engagement, community coaching, workplace assistance or group day services shall not exceed 66 hours per week. Supported employment services shall take place in nonresidential settings separate from the individual's home.

4. For time-limited and service authorized periods (not to exceed 40 hours) individual supported employment may be provided in combination with day services or residential services for purposes of job discovery.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1066 A and B.

12VAC30-120-1036. Covered services: supported living residential; sponsored residential.

A. Supported living residential.

1. Service description. Supported living residential shall take place in an apartment setting that shall be operated by a DBHDS-licensed provider of supervised living residential services. These services shall consist of skill-building, routine and general supports, and safety supports that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Service providers shall be reimbursed only for the amount and type of supported living residential services that are

included in the individual's ISP. Supported living residential services shall be authorized for Medicaid reimbursement in the Plan for Supports only when the individual requires these services. Supported living residential is a tiered service for reimbursement purposes. Providers shall only be reimbursed for the individual's assigned level and tier. Supported living residential services shall be provided to the individual in the form of around-the-clock availability of paid provider staff who have the ability to respond in a timely manner. These services may be provided individually or simultaneously to more than one individual living in the apartment, depending on the required support or supports.

2. Criteria. This service shall be provided to individuals who require (i) skills development related to personal care activities (such as ADLs, communication, and IADLs); (ii) help to replace challenging behaviors with positive, accepted behaviors for home and community-based environments; (iii) monitoring of health and physical conditions and the provision of supports with medication or other medical needs; (iv) transportation to and from training sites and community resources or activities; (v) general supports as needed; and (vi) safety supports to ensure the individual's health and safety.

3. Units and limits.

a. The unit of service shall be one day and billing shall not exceed 344 days per ISP year.

b. Total billing shall not exceed the amount authorized in the ISP. The provider shall maintain documentation of the dates that services have been provided and of specific circumstances that prevented provision of all of the scheduled services, should that occur. This service shall be provided on an individual-specific basis according to the ISP and service setting requirements;

c. Supported living residential services shall not be provided to any individual enrolled in the waiver who receives personal assistance services or other residential services under the CL Waiver, such as group home residential services, shared living, in-home support services, or sponsored residential services, that provide a comparable level of care.

d. Room and board shall not be components of this service;

e. Supported living residential services shall not be used solely to provide routine or emergency respite care for the family/caregiver with whom the individual lives; and

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

4. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1064.

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B. Sponsored residential services.

1. Service description. Sponsored residential services means residential services that consist of skill-building, routine supports, general supports, and safety supports that are provided in the homes of families or persons (sponsors) providing supports under the supervision of a DBHDS-licensed provider that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings. This service shall include skills development with the provision of supports, as needed. After January 1, 2017, sponsored living residential services shall be a tiered service for reimbursement purposes. After January 1, 2017, providers shall only be reimbursed for the individual's assigned level and tier.

2. Criteria. This service shall only be authorized for Medicaid reimbursement when, through the person-centered planning process, this service is determined necessary to meet the individual's needs. These services may be provided individually or simultaneously to up to two individuals living in the same home, depending on the required support.

3. Allowable activities shall include (i) skill-building and routine supports related to personal care activities, (such as ADLs), communication and IADLs; (ii) skill-building and routine and safety supports related to the use of community resources; (iii) replacing challenging behaviors with positive, accepted behaviors; (iv) monitoring and supporting health and physical conditions, and the provision of supports with medication management and other medical needs; (v) routine and safety supports with transportation to and from training sites and community resources or activities; and (vi) providing general supports and safety supports.

4. Units and limits.

a. The unit of service shall be one day and billing shall not exceed 344 days per ISP year, as indicated in the Plan for Supports of the individuals who are authorized to receive this service.

b. This service shall not be covered for individuals who are simultaneously receiving shared living services, supported living services, in-home support services, or group home residential services.

c. DMAS coverage of this service shall be limited to no more than two individuals per residential setting. Providers shall not bill for services rendered to more than two individuals living in the same residential setting.

d. This service shall be provided to individuals up to 24-hours per day by the sponsor family who shall be physically present with the individual.

5. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1064.

12VAC30-120-1037. Covered services: therapeutic consultation.

A. Therapeutic consultation. Service description. This service shall provide assessments, development of a therapeutic consultation plan, and teaching in any of the following specialty areas to assist family members, caregivers, and other service providers in assisting the individual enrolled in the waiver. The specialty areas shall be (i) psychology, (ii) behavioral consultation services, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services shall be based on the individuals' Individual Support Plan and shall be provided to an individual for whom specialized consultation is clinically necessary. Therapeutic consultation services may be provided in individuals' homes and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to facilitate implementation of individuals' desired outcomes as identified in their Individual Support Plans.

B. Service criteria. In order to qualify for these services, the individual shall have a documented need for consultation in any of these services. Documented need shall indicate that the ISP cannot be implemented effectively and efficiently without such consultation as provided by this covered service and approved through service authorization.

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

2. Other than behavioral consultation, therapeutic consultation services shall not include direct therapy provided to individuals enrolled in the waiver and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance. Behavior consultation services may include direct behavioral interventions and demonstration to family members/staff of such interventions.

C. Service units and limits.

1. The unit of service shall be one hour.

2. The services shall be explicitly detailed in the ISP.

3. Travel time, written preparation, and telephone communication shall be considered as in-kind expenses within this service and shall not be reimbursed as separate items.

4. Therapeutic consultation shall not be billed solely for purposes of monitoring the individual.

5. Only behavioral consultation in this therapeutic consultation service may be offered in the absence of any other waiver service.

D. Allowable activities shall include:

1. Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation;
2. Observing the individual in daily activities and natural environments;
3. Assessing the individual's need for an assistive device or modification or adjustment, or both, in the environment or services including reviewing documentation and evaluating the efficacy of assistive devices and interventions identified in the therapeutic consultation plan;
4. Developing data collection mechanisms and collecting baseline data as appropriate for the type of consultation service provided;
5. Observing and assessing the current interventions, support strategies, or assistive devices being used with the individual;
6. Designing a written therapeutic consultation plan detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes, including recommendations related to specific devices, technology, or adaptation of other training programs or activities including training relevant persons to better support the individual simply by observing the individual's environment, daily routines, and personal interactions;
7. Demonstrating specialized, therapeutic interventions, individualized supports, or assistive devices;
8. Training family/caregivers and other relevant persons to assist the individual in using an assistive device; to implement specialized, therapeutic interventions; or adjust currently utilized support techniques;
9. Intervening directly, by behavioral consultants, with the individual and demonstrating to family/caregivers/staff such interventions. Such intervention modalities shall relate to the individual's identified behavioral needs as detailed in established specific goals and procedures set out in the ISP.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1068 C.

12VAC30-120-1038. Covered services: transition services.

This service shall be the same as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

12VAC30-120-1039. Covered services: workplace assistance services.

A. Workplace assistance services description. Workplace assistance services means supports provided to an individual who has completed job development and completed or nearly completed job placement training (i.e., supported employment) but requires more than the typical job coach services to maintain stabilization in his employment. These

services are supplementary to individual supported employment services.

B. Workplace assistance criteria.

1. The activity shall not be work skill training related that would normally be provided by a job coach;
2. Services shall be delivered in their natural setting, where and when they are needed; and
3. Services shall facilitate the maintenance of and inclusion in an employment situation.

C. Allowable activities include:

1. Habilitative supports related to nonwork skills needed for the individual to maintain employment;
2. Habilitative supports to make and strengthen community connections; and
3. Safety supports to ensure the individual's health and safety.

D. Workplace assistance service units and service limitations.

1. A unit shall be one hour. This service may be provided during the time that the individual being served is working, up to and including 40 hours a week. There shall be no annual limit on how long these services may remain authorized.
2. This service shall not be provided simultaneously with work-related personal assistance services. This service shall not be provided solely for the purpose of providing assistance with ADLs to the individual when he is working.
3. The service delivery ratio shall be one staff person to one waiver individual. Workplace assistance services, alone or in combination with community engagement, community coaching, supported employment, or group day services shall not exceed 66 hours per week.
4. The provider shall render onsite habilitative supports related to behavior, health, time management, or other skills that otherwise would endanger the individual's continued employment. The provider may provide assistance to the individual with personal care needs as well; however, this cannot be the sole use of workplace assistance services.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-501 et seq. and 12VAC30-120-1066 C.

12VAC30-120-1040. General requirements for participating providers. (Repealed.)

~~A. Requests for participation as Medicaid providers of waiver services shall be screened by DMAS or its designated contractor to determine whether the provider applicant meets the basic requirements for provider participation. All providers must be currently enrolled with DMAS in order to be reimbursed for services rendered. Providers who are not~~

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enrolled shall not be reimbursed. Consumer directed assistants shall not be considered Medicaid providers for the purpose of enrollment procedures.

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

1. For services that have licensure and certification requirements, the standards of any state licensure or certification requirements, or both as applicable pursuant to 42 CFR 441.302;
2. Disclosure of ownership pursuant to 42 CFR 455.104 and 42 CFR 455.105; and
3. The ability to document and maintain individual records in accordance with state and federal requirements.

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

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal health care programs, including Medicaid (i.e., via the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program Integrity/Exclusions, 600 E. Broad St., Suite 1300, Richmond, VA 23219 or emailed to providerexclusion@dmass.virginia.gov;
2. Immediately notify DMAS and DBHDS, in writing, of any change in the information that the provider previously submitted, for the purpose of the provider agreement, to DMAS and DBHDS;
3. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid program at the time the service or services were performed;
4. Assure the individual's freedom to refuse medical care, treatment, and services;
5. Accept referrals for services only when staff is available to initiate services and perform, as may be required, such services on an ongoing basis;
6. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; the Fair Housing Amendments Act of 1988 (42 USC § 3601 et seq.); and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the

areas of employment, public accommodations, state and local government services, and telecommunications;

7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

8. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by the DMAS payment methodology from the individual's authorization date for the waiver services;

9. Use program designated billing forms for submission of charges;

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

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

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

11. Agree to furnish information on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement. No business or professional records shall be created or modified by providers once an audit has been initiated;

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

13. Hold confidential and use for authorized DMAS or DBHDS purposes only, all medical assistance information regarding individuals served pursuant to Subpart F of 42 CFR Part 431, 12VAC30-20-90, and any other applicable state or federal law. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the

data is necessary for the functioning of DMAS in conjunction with the cited laws;

14. Notify DMAS of change of ownership. When ownership of the provider changes, DMAS shall be notified at least 15 calendar days before the date of change;

15. Comply with applicable standards that meet the requirements for board and care facilities for all facilities covered by § 1616(e) of the Social Security Act in which home and community based waiver services will be provided. Health and safety standards shall be monitored through the DBHDS' licensure standards or through VDSS approved standards for adult foster care providers;

16. Immediately report, pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, such knowledge if a participating provider knows or suspects that an individual enrolled in a home and community based waiver service is being abused, neglected, or exploited. The party having knowledge or suspicion of the abuse, neglect, or exploitation shall from first knowledge report the same to the local department of social services' adult or child protective services worker and to DBHDS Offices of Licensing and Human Rights as applicable;

17. Perform criminal history record checks for barrier crimes, as defined in 12VAC30-120-1000, within 15 days from the date of employment. If the individual enrolled in the waiver to be served is a minor child, perform a search of the VDSS Child Protective Services Central Registry. The personal care/respite assistant or companion for either agency directed or consumer directed services shall not be compensated for services provided to the individual enrolled in the waiver if any of these records checks verifies that the assistant or companion has been convicted of crimes described in § 37.2-416 of the Code of Virginia or if the assistant or companion has a finding in the VDSS Child Protective Services Central Registry; or if the assistant or companion is determined by a local department of social services as having abused, neglected, or exploited an adult 60 years of age or older or an adult who is 18 years of age if incapacitated. The personal assistant or companion shall not be reimbursed by DMAS for services provided to the individual enrolled in the waiver effective on the date and thereafter that the criminal record check verifies that the assistant or companion has been convicted of crimes described in § 37.2-416 of the Code of Virginia. The personal assistant (for either agency directed or consumer directed services) and companion shall notify either their employer or the services facilitator, the individual enrolled in the waiver and EOR, as appropriate, of all convictions occurring subsequent to this record check. Failure to report any subsequent convictions may result in termination of employment. Assistants or companions who refuse to consent to child protective services registry checks shall not be eligible for Medicaid reimbursement of services that they may provide;

18. Refrain from performing any type of direct marketing activities, as defined in 12VAC30-120-1000, to Medicaid individuals;

19. Adhere to the provider participation agreement and the Virginia Medicaid Provider Manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the Virginia Medicaid Provider Manual; and

20. Participate, as may be requested, in the completion of the DBHDS approved assessment instrument when the provider possesses specific, relevant information about the individual enrolled in the waiver.

D. DMAS or its contractor shall be responsible for assuring continued adherence to provider participation standards. DMAS or its contractor shall conduct ongoing monitoring of compliance with provider participation standards and DMAS' policies and periodically recertify each provider for participation agreement renewal to provide home and community based waiver services. A provider's noncompliance with DMAS' policies and procedures, as required in the provider's participation agreement, may result in a written request from DMAS for a corrective action plan that details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies that have been cited. Failure to comply may result in termination of the provider enrollment agreement as well as other sanctions.

E. Felony convictions. DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. Territories shall, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations shall be effective immediately and conform to 12VAC30-10-690 and 12VAC30-20-491.

1. Providers shall not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction.

2. Except as otherwise provided by applicable state or federal law, the Medicaid provider agreement may be terminated by DMAS at will on 30 days written notice. The agreement may be terminated if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program.

3. A participating provider may voluntarily terminate his participation with DMAS by providing 30 days written notification.

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F. Providers shall be required to use IDOLS to document services, for purposes of reimbursement, to individuals enrolled in the waiver. The DBHDS approved assessment shall be the Supports Intensity Scale (SIS), as published by the American Association on Intellectual and Developmental Disabilities and as may be amended from time to time.

G. Fiscal employer/agent requirements. Pursuant to a duly negotiated contract or interagency agreement, the contractor or entity shall be reimbursed by DMAS to perform certain employer functions including, but not limited to, payroll and bookkeeping functions on the part of the individual/employer who is receiving consumer directed services.

1. The fiscal employer/agent shall be responsible for administering payroll services on behalf of the individual enrolled in the waiver including, but not limited to:

- a. Collecting and maintaining citizenship and alien status employment eligibility information required by the Department of Homeland Security;
- b. Securing all necessary authorizations and approvals in accordance with state and federal tax requirements;
- c. Deducting and filing state and federal income and employment taxes and other withholdings;
- d. Verifying that assistants' or companions' submitted timesheets do not exceed the maximum hours prior authorized for individuals enrolled in the waiver;
- e. Processing timesheets for payment;
- f. Making all deposits of income taxes, FICA, and other withholdings according to state and federal requirements; and
- g. Distributing bi weekly payroll checks to individuals' assistants.

2. All timesheet discrepancies shall be reported promptly upon their identification to DMAS for investigation and resolution.

3. The fiscal employer/agent shall maintain records and information as required by DMAS and state and federal laws and regulations and make such records available upon DMAS' request in the needed format.

4. The fiscal employer/agent shall establish and operate a customer service center to respond to individuals' and assistants' payroll and related inquiries.

5. The fiscal employer/agent shall maintain confidentiality of all Medicaid information pursuant to HIPAA and DMAS requirements. Should any breaches of confidential information occur, the fiscal/employer agent shall assume all liabilities under both state and federal law.

H. Changes to or termination of services. DBHDS shall have the authority, subject to final approval by DMAS, to approve changes to an individual's Individual Support Plan, based on the recommendations of the case management provider.

1. Providers of direct services shall be responsible for modifying their plans for supports, with the involvement of the individual enrolled in the waiver and the individual's family/caregiver, as appropriate, and submitting such revised plans for supports to the case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered.

a. The case manager shall review the need for a change and may recommend a change to the plan for supports to the DBHDS staff.

b. DBHDS shall review and approve, deny, or suspend for additional information, the requested change or changes to the individual's Plan for Supports. DBHDS shall communicate its determination to the case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency within three business days of receipt of the request for change.

2. The individual enrolled in the waiver and the individual's family/caregiver, as appropriate, shall be notified in writing by the case manager of his right to appeal pursuant to DMAS client appeals regulations, Part I of 12VAC30-110, about the decision or decisions to reduce, terminate, suspend, or deny services. The case manager shall submit this written notification to the individual enrolled in the waiver within 10 business days of the decision.

3. In a nonemergency situation, when a participating provider determines that services to an individual enrolled in the waiver must be terminated, the participating provider shall give the individual and the individual's family/caregiver, as appropriate, and case manager 10 business days written notification of the provider's intent to discontinue services. The notification letter shall provide the reasons for the planned termination and the effective date the provider will be discontinuing services. The effective date shall be at least 10 business days from the date of the notification letter. The individual enrolled in the waiver shall be eligible for appeal rights in this situation and may pursue services from another provider.

4. In an emergency situation when the health, safety, or welfare of the individual enrolled in the waiver, other individuals in that setting, or provider personnel are endangered, the case manager and DBHDS shall be notified prior to discontinuing services. The 10 business-day prior written notification period shall not be required. The local department of social services adult protective services unit or child protective services unit, as appropriate, and DBHDS Offices of Licensing and Human Rights shall be notified immediately by the case manager and the provider when the individual's health, safety, or welfare may be in danger.

~~5. The case manager shall have the responsibility to identify those individuals who no longer meet the level of care criteria or for whom home and community based waiver services are no longer an appropriate alternative. In such situations, such individuals shall be discharged from the waiver.~~

~~a. The case manager shall notify the individual of this determination and afford the individual and family/caregiver, as appropriate, with his right to appeal such discharge.~~

~~b. The individual shall be entitled to the continuation of his waiver services pending the final outcome of his appeal action. Should the appeal action confirm the case manager's determination that the individual shall be discharged from the waiver, the individual shall be responsible for the costs of his waiver services incurred by DMAS during his appeal action.~~

12VAC30-120-1058. Provider requirements: services facilitation.

Provider requirements for services facilitation shall be the same as those set forth in 12VAC30-120-759 B and 12VAC30-120-770 B.

12VAC30-120-1059. Provider requirements for companion services, personal assistance, and respite services.

A. Licensure Requirements for agency directed services. For companion, personal assistance, and respite services, the provider shall be licensed by DBHDS as either a residential service provider, supportive in-home residential service provider, day support service provider, or respite service provider or shall meet the DMAS criteria to be a personal care or respite care provider.

B. Supervision requirements for agency-directed companion, personal assistance, and respite services.

1. A supervisor shall provide ongoing supervision of all personal assistants, companions, and respite assistants.

2. For DMAS-enrolled personal assistance and respite providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who shall provide ongoing supervision of all assistants. The supervising RN or LPN shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

3. For companion service providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who shall provide ongoing supervision of all companions. The supervising RN or LPN shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility or shall have a bachelor's degree in a human services field

and at least one year of experience working with individuals with developmental disabilities.

4. The supervisor shall make a home visit to conduct an initial assessment prior to the start of services for all individuals enrolled in the waiver requesting and who have been approved to receive personal assistance, companion, or respite services. The supervisor shall also perform any subsequent reassessments or changes to the Plan for Supports. All changes that are indicated for an individual's Plan for Supports shall be reviewed with and agreed to by the individual and, if appropriate, the family/caregiver.

5. The supervisor shall make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits shall be every 30 to 90 days under the agency-directed model, depending on the individual's needs.

6. Based on continuing evaluations of the assistant's/companion's performance and individual's needs, the supervisor shall identify any gaps in the assistant's/companion's ability to function competently and shall provide training as indicated.

C. Service facilitation requirements for companion, personal assistance, and respite services shall be the same as those set forth in 12VAC30-120-759 A and 12VAC30-120-770.

D. Family members as providers in companion, personal assistance, and respite services (agency-directed and consumer-directed).

1. Individuals paid by DMAS shall not be the parents of individuals enrolled in the waiver who or a minor child or the individual's spouse.

2. Persons rendering services for reimbursement by DMAS shall not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion or assistant services unless there is objective written documentation completed by the services facilitator, or the EOR when the individual does not select services facilitation, as to why there are no other providers available to provide services.

3. Family members who are approved to be reimbursed for providing these services shall meet the same qualifications as all other staff providing services.

E. Required documentation (agency-directed and consumer-directed). In addition to the requirements in 12VAC30-120-501 et seq., the following requirements for personal assistance services, respite services, and companion services apply:

1. Agency-directed providers or the services facilitator, or the EOR in the absence of a services facilitator, shall maintain records regarding each individual who is receiving services.

2. At a minimum, these records shall contain:

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a. A copy of the completed DBHDS-approved SIS[®] assessment and, as needed, an initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated.

b. The provider's Plan for Supports, that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, and required or desired supports;

(2) The individual's support activities to meet the identified outcomes; and

(3) Services to be rendered and the frequency of such services to accomplish the above desired outcomes and support activities; and

c. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review shall be submitted to the support coordinator/case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate;

d. The services supervisor or CD services facilitator shall document in the individual's record in a summary note following significant contacts with the assistant/companion and home visits with the individual the following:

(1) Whether services continue to be appropriate;

(2) Whether the Plan for Supports is adequate to meet the individual's needs or changes are needed in the plan;

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

(4) The presence or absence of the assistant/companion during the supervisor's visit;

(5) Any suspected abuse, neglect, or exploitation and to whom it was reported; and

(6) Any hospitalization or change in medical condition, functioning, or cognitive status.

e. All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator/case manager, DMAS, and DBHDS;

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

g. Documentation provided by the support coordinator/case manager as to why there are no providers other than family members available to render assistant/companion services if this service is part of the individual's Plan for Supports.

3. The records of individuals enrolled in the waiver who are receiving services shall contain:

a. The specific services delivered to the individual enrolled in the waiver, dated the day that such services were provided, the number of hours as outlined in the Plan for Supports, the individual's responses, and observations of the individual's physical and emotional condition; and

b. At a minimum, monthly verification by the residential supervisor of the services and hours rendered and billed to DMAS.

F. Consumer-directed services: enrollment and disenrollment.

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

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

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

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

2. Voluntary or involuntary disenrollment of consumer-directed services. Either voluntary or involuntary disenrollment of consumer-directed services may occur. In either voluntary or involuntary situations, the individual enrolled in the waiver shall be permitted to select an agency from which to receive his personal assistance, respite, or companion services. If the individual either fails to select an agency or refuses to do so, then one will be selected for him by either the support coordinator/case manager or services facilitator.

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

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

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

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

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

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

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

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

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

(4) Provide written notice to the individual and EOR, as appropriate, of the right to appeal, pursuant to 12VAC30-110, such involuntary termination of consumer direction. Except in emergency situations in which the health or safety of the individual is at serious risk, such notice shall be given at least 10 business days prior to the effective date of the termination of consumer direction. In cases of an emergency situation, notice of the right to appeal shall be given to the individual but the requirement to provide notice at least 10 business days in advance shall not apply.

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

G. Consumer-directed attendant requirements for companion, personal assistance, and respite services.

1. For the consumer-directed model, there shall be a services facilitator (or person serving in this capacity) meeting the requirements found in 12VAC30-120-759 B and 12VAC30-120-770.

2. Persons functioning as CD attendants/companions shall meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic math skills and be able to read and write English to the degree required to function in this capacity and create and maintain the required documentation;

c. Be capable of following a Plan for Supports with minimal supervision and be physically able to perform the required work;

d. Possess a valid social security number that has been issued by the Social Security Administration;

e. Be capable of aiding in IADLs;

f. Receive an annual tuberculosis screening in accordance with guidelines published on the Virginia Department of Health website;

g. Be willing to attend training at the individual's and the individual family/caregiver's, as appropriate, request;

h. Understand and agree to comply with DMAS waiver requirements as contained in 12VAC30-120-1000 et seq.; and

i. Not be the EOR who is directing the individual's care.

3. If an individual or his family/caregiver, as appropriate, is consistently unable to hire and retain an employee to provide consumer-directed services, the services facilitator shall contact the support coordinator/case manager and DBHDS to transfer the individual, at the choice of the individual or his family/caregiver, as appropriate, to a provider that provides Medicaid-funded agency-directed personal care assistance or respite care services. The CD services facilitator shall make arrangements with the support coordinator/case manager to have the individual transferred.

H. Requirements for agency-directed companions/assistants.

1. Assistants/companions shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual and developmental disabilities, as ensured by the provider prior to being assigned to support an individual, and have the required skills and training to perform the services as specified in the individual's Plan for Supports and related supporting documentation. Assistants'/companions' required training, as further detailed in the applicable provider manual, shall be met in one of the following ways:

a. Registration with the Board of Nursing as a certified nurse aide;

b. Graduation from an approved educational curriculum as listed by the Board of Nursing; or

c. Completion of the provider's educational curriculum, as conducted by a licensed RN who shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

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

3. Provider inability to render services and substitution of assistants (agency-directed model). When assistants/companions are absent or otherwise unable to

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render scheduled supports to individuals enrolled in the waiver, the provider shall be responsible for ensuring that services continue to be provided to the affected individuals.

a. The provider may either provide another assistant/companion, obtain a substitute assistant/companion from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another personal care assistance or respite provider. The provider that has the service authorization to provide services to the individual enrolled in the waiver shall contact the support coordinator/case manager to determine if additional or modified service authorization is necessary.

b. If no other provider is available who can supply a substitute assistant/companion, the provider shall notify the individual and the individual's family/caregiver, as appropriate, and the support coordinator/case manager so that the support coordinator/case manager may find another available provider of the individual's choice.

4. During temporary, short-term lapses in coverage that are not expected to exceed approximately two weeks in duration, the following procedures shall apply:

a. The service authorized provider shall provide the supervision for the substitute assistant/companion;

b. The provider of the substitute assistant/companion shall send a copy of the assistant's/companion's daily documentation signed by the assistant/companion, the individual, and the individual's family/caregiver, as appropriate, to the provider having the service authorization; and

c. The service authorized provider shall bill DMAS for services rendered by the substitute assistant/companion.

5. If a provider secures a substitute assistant/companion, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant/companion and documentation that the substitute assistant's/companion's qualifications meet DMAS requirements. The two providers involved shall be responsible for negotiating the financial arrangements of paying the substitute assistant/companion.

I. Agency-directed documentation requirements:

1. The record for agency-directed service providers shall contain:

a. The specific services delivered to the individual enrolled in the waiver by the assistant/companion dated the day of service delivery and the individual's responses;

b. The personal assistant's/companion's arrival and departure times;

c. The personal assistant's/companion's weekly comments or observations about the individual enrolled

in the waiver to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The personal assistant's/companion's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

e. These records shall be separated from those of other nonwaiver services, such as home health services. At a minimum these records shall contain:

(1) The most recently updated plan of care for supports and supporting documentation, and all provider documentation;

(2) A copy of the SIS[®] assessment, the initial assessment by the RN supervisory nurse or support coordinator/case manager/services facilitator completed prior to or on the date services are initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse or support coordinator/case manager/services facilitator; and

(3) Nurses or support coordinator/case manager/services facilitator summarizing notes recorded and dated during any contacts with the CD attendant and during supervisory visits to the individual's home;

J. Special requirements for respite services.

1. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator shall conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite service authorization period. The supervisor or services facilitator, as appropriate, shall review the use of respite services either every six months or upon the use of 240 respite service hours, whichever comes first.

2. When respite services are routine in nature, that is occurring with a scheduled regularity for specific periods of time, and offered in conjunction with personal assistance, the supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor or services facilitator, as appropriate, shall document supervision of respite services separately. For this purpose, the same individual record shall be used with a separate section for respite services documentation.

12VAC30-120-1060. Participation standards for provision of services; providers' requirements. (Repealed.)

~~A. The required documentation for residential support services, day support services, supported employment services, and prevocational support shall be as follows:~~

~~1. A completed copy of the DBHDS approved SIS assessment form or its approved alternative form during the phase in period.~~

2. A Plan for Supports containing, at a minimum, the following elements:

- a. The individual's strengths, desired outcomes, required or desired supports or both, and skill building needs;
- b. The individual's support activities to meet the identified outcomes;
- c. The services to be rendered and the schedule of such services to accomplish the above desired outcomes and support activities;
- d. A timetable for the accomplishment of the individual's desired outcomes and support activities;
- e. The estimated duration of the individual's needs for services; and
- f. The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

3. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be submitted to the case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.

4. All correspondence to the individual and the individual's family/caregiver, as appropriate, the case manager, DMAS, and DBHDS.

5. Written documentation of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

B. The required documentation for personal assistance services, respite services, and companion services shall be as set out in this subsection. The agency provider holding the service authorization or the services facilitator, or the EOR in the absence of a services facilitator, shall maintain records regarding each individual who is receiving services. At a minimum, these records shall contain:

1. A copy of the completed DBHDS approved SIS assessment (or its approved alternative during the phase in period) and, as needed, an initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated.

2. A Plan for Supports, that contains, at a minimum, the following elements:

- a. The individual's strengths, desired outcomes, required or desired supports;
- b. The individual's support activities to meet these identified outcomes;
- c. Services to be rendered and the frequency of such services to accomplish the above desired outcomes and support activities; and

d. For the agency directed model, the provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports. For the consumer directed model, the identifying information for the assistant or assistants and the Employer of Record.

3. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be submitted to the case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.

4. The companion services supervisor or CD services facilitator, as required by 12VAC30-120-1020, shall document in the individual's record in a summary note following significant contacts with the companion and home visits with the individual:

- a. Whether companion services continue to be appropriate;
- b. Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;
- c. The individual's satisfaction with the service;
- d. The presence or absence of the companion during the supervisor's visit;
- e. Any suspected abuse, neglect, or exploitation and to whom it was reported; and
- f. Any hospitalization or change in medical condition, and functioning or cognitive status;

5. All correspondence to the individual and the individual's family/caregiver, as appropriate, the case manager, DMAS, and DBHDS;

6. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual; and

7. Documentation provided by the case manager as to why there are no providers other than family members available to render respite assistant care if this service is part of the individual's Plan for Supports.

C. The required documentation for assistive technology, environmental modifications (EM), and Personal Emergency Response Systems (PERS) shall be as follows:

1. The appropriate IDOLS documentation, to be completed by the case manager, may serve as the Plan for Supports for the provision of AT, EM, and PERS services. A rehabilitation engineer may be involved for AT or EM services if disability expertise is required that a general contractor may not have. The Plan for Supports/IDOL shall include justification and explanation that a rehabilitation engineer is needed, if one is required. The IDOL shall be

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submitted to the state designated agency or its contractor in order for service authorization to occur;

2. ~~Written documentation for AT services regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as DME and supplies, and that it is not available from a DME provider;~~

3. ~~AT documentation of the recommendation for the item by a qualified professional;~~

4. ~~Documentation of the date services are rendered and the amount of service that is needed;~~

5. ~~Any other relevant information regarding the device or modification;~~

6. ~~Documentation in the case management record of notification by the designated individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item; and~~

7. ~~Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.~~

D. Assistive technology (AT). In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, AT shall be provided by DMAS-enrolled durable medical equipment (DME) providers or DMAS-enrolled CSBs/BHAs with an ID Waiver provider agreement to provide AT. DME shall be provided in accordance with 12VAC30-50-165.

E. Companion services (both agency directed and consumer directed). In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, companion service providers shall meet the following qualifications:

1. For the agency directed model, the provider shall be licensed by DBHDS as either a residential service provider, supportive in-home residential service provider, day support service provider, or respite service provider or shall meet the DMAS criteria to be a personal care/respite care provider.

2. For the consumer directed model, there may be a services facilitator (or person serving in this capacity) meeting the requirements found in 12VAC30-120-1020.

3. Companion qualifications. Persons functioning as companions shall meet the following requirements:

a. Be at least 18 years of age;

b. Be able to read and write English to the degree required to function in this capacity and possess basic math skills;

c. Be capable of following a Plan for Supports with minimal supervision and be physically able to perform the required work;

d. Possess a valid social security number that has been issued by the Social Security Administration to the person who is to function as the companion;

e. Be capable of aiding in IADLs; and

f. Receive an annual tuberculosis screening.

4. ~~Persons rendering companion services for reimbursement by DMAS shall not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective written documentation completed by the services facilitator, or the EOR when the individual does not select services facilitation, as to why there are no other providers available to provide companion services.~~

a. ~~Family members who are approved to be reimbursed by DMAS to provide companion services shall meet all of the companion qualifications.~~

b. ~~Companion services shall not be provided by adult foster care providers or any other paid caregivers for an individual residing in that foster care home.~~

5. ~~For the agency directed model, companions shall be employees of enrolled providers that have participation agreements with DMAS to provide companion services. Providers shall be required to have a companion services supervisor to monitor companion services. The companion services supervisor shall have a bachelor's degree in a human services field and have at least one year of experience working in the ID field, or be a licensed practical nurse (LPN) or a registered nurse (RN) with at least one year of experience working in the ID field. Such LPNs and RNs shall have the appropriate current licenses to either practice nursing in the Commonwealth or have multi-state licensure privilege as defined herein.~~

6. ~~The companion services supervisor or services facilitator, as appropriate, shall conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of such services and to establish a Plan for Supports for the individual enrolled in the waiver. The companion services supervisor or services facilitator must provide quarterly follow up home visits to monitor the provision of services under the agency directed model and semi annually (every six months) under the consumer directed model or more often as needed.~~

7. ~~In addition to the requirements in subdivisions 1 through 6 of this subsection the companion record for agency directed service providers must also contain:~~

a. ~~The specific services delivered to the individual enrolled in the waiver by the companion, dated the day of service delivery, and the individual's responses;~~

b. ~~The companion's arrival and departure times;~~

c. ~~The companion's weekly comments or observations about the individual enrolled in the waiver to include~~

observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The companion's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

8. ~~Consumer directed model companion record. In addition to the requirements outlined in this subsection, the companion record for services facilitators must contain:~~

a. ~~The services facilitator's dated notes documenting any contacts with the individual enrolled in the waiver and the individual's family/caregiver, as appropriate, and visits to the individual's home;~~

b. ~~Documentation of training provided to the companion by the individual or EOR, as appropriate;~~

c. ~~Documentation of all employer management training provided to the individual enrolled in the waiver or the EOR, including the individual's and the EOR's, as appropriate, receipt of training on their legal responsibility for the accuracy and timeliness of the companion's timesheets; and~~

d. ~~All documents signed by the individual enrolled in the waiver and the EOR that acknowledge their responsibilities and legal liabilities as the companion's or companions' employer, as appropriate.~~

F. ~~Crisis stabilization services. In addition to the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, the following crisis stabilization provider qualifications shall apply:~~

1. ~~A crisis stabilization services provider shall be licensed by DBHDS as a provider of either outpatient services, crisis stabilization services, residential services with a crisis stabilization track, supportive residential services with a crisis stabilization track, or day support services with a crisis stabilization track.~~

2. ~~The provider shall employ or use QMRPs, licensed mental health professionals, or other qualified personnel who have demonstrated competence to provide crisis stabilization and related activities to individuals with ID who are experiencing serious psychiatric or behavioral problems.~~

3. ~~To provide the crisis supervision component, providers must be licensed by DBHDS as providers of residential services, supportive in home residential services, or day support services. Documentation of providers' qualifications shall be maintained for review by DBHDS and DMAS staff or DMAS' designated agent.~~

4. ~~A Plan for Supports must be developed or revised and submitted to the case manager for submission to DBHDS~~

~~within 72 hours of the requested start date for authorization.~~

5. ~~Required documentation in the individual's record. The provider shall maintain a record regarding each individual enrolled in the waiver who is receiving crisis stabilization services. At a minimum, the record shall contain the following:~~

a. ~~Documentation of the face to face assessment and any reassessments completed by a QMRP;~~

b. ~~A Plan for Supports that contains, at a minimum, the following elements:~~

(1) ~~The individual's strengths, desired outcomes, required or desired supports;~~

(2) ~~Services to be rendered and the frequency of services to accomplish these desired outcomes and support activities;~~

(3) ~~A timetable for the accomplishment of the individual's desired outcomes and support activities;~~

(4) ~~The estimated duration of the individual's needs for services; and~~

(5) ~~The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and~~

e. ~~Documentation indicating the dates and times of crisis stabilization services, the amount and type of service or services provided, and specific information regarding the individual's response to the services and supports as agreed to in the Plan for Supports.~~

G. ~~Day support services. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, day support providers, for both intensive and regular service levels, shall meet the following additional requirements:~~

1. ~~The provider of day support services must be specifically licensed by DBHDS as a provider of day support services. (12VAC 35-105-20)~~

2. ~~In addition to licensing requirements, day support staff shall also have training in the characteristics of intellectual disabilities and the appropriate interventions, skill building strategies, and support methods for individuals with intellectual disabilities and such functional limitations. All providers of day support services shall pass an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS' defined procedures. (See www.dbhds.virginia.gov for further information.)~~

3. ~~Documentation confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. An~~

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attendance log or similar document must be maintained that indicates the individual's name, date, type of services rendered, staff signature and date, and the number of service units delivered, in accordance with the DMAS fee schedule.

4. Documentation indicating whether the services were center based or noncenter based shall be included on the Plan for Supports.

5. In instances where day support staff may be required to ride with the individual enrolled in the waiver to and from day support services, the day support staff transportation time may be billed as day support services and documentation maintained, provided that billing for this time does not exceed 25% of the total time spent in day support services for that day.

6. If intensive day support services are requested, documentation indicating the specific supports and the reasons they are needed shall be included in the Plan for Supports. For ongoing intensive day support services, there shall be specific documentation of the ongoing needs and associated staff supports.

H. Environmental modifications. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, environmental modifications shall be provided in accordance with all applicable federal, state, or local building codes and laws by CSBs/BHAs contractors or DMAS enrolled providers.

I. Personal assistance services (both consumer directed and agency directed models). In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, personal assistance providers shall meet additional provider requirements:

1. For the agency directed model, services shall be provided by an enrolled DMAS personal care provider or by a residential services provider licensed by the DBHDS that is also enrolled with DMAS. All agency directed personal assistants shall pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

2. For the CD model, services shall meet the requirements found in 12VAC30-120-1020.

3. For DBHDS licensed residential services providers, a residential supervisor shall provide ongoing supervision of all personal assistants.

4. For DMAS enrolled personal care providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who shall provide ongoing supervision of all assistants. The supervising RN or LPN

shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/ID, or nursing facility.

5. For agency directed services, the supervisor, or for CD services the services facilitator, shall make a home visit to conduct an initial assessment prior to the start of services for all individuals enrolled in the waiver requesting, and who have been approved to receive, personal assistance services. The supervisor or services facilitator, as appropriate, shall also perform any subsequent reassessments or changes to the Plan for Supports. All changes that are indicated for an individual's Plan for Supports shall be reviewed with and agreed to by the individual and, if appropriate, the family/caregiver.

6. The supervisor or services facilitator, as appropriate, shall make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits shall be every 30 to 90 days under the agency directed model and semi-annually (every six months) under the CD model of services, depending on the individual's needs.

7. Based on continuing evaluations of the assistant's performance and individual's needs, the supervisor (for agency directed services) or the individual or the employer of record (EOR) (for the CD model) shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

8. Qualifications for consumer directed personal assistants. The assistant shall:

a. Be 18 years of age or older and possess a valid social security number that has been issued by the Social Security Administration to the person who is to function as the attendant;

b. Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;

c. Have the required skills and physical abilities to perform the services as specified in the individual's Plan for Supports;

d. Be willing to attend training at the individual's and EOR's, as appropriate, request;

e. Understand and agree to comply with the DMAS' ID Waiver requirements as contained in this part (12VAC30-120-1000 et seq.); and

f. Receive an annual tuberculosis screening.

9. Additional requirements for DMAS enrolled (agency directed) personal care providers.

a. Personal assistants shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual/developmental disabilities, as

ensured by the provider prior to being assigned to support an individual, and have the required skills and training to perform the services as specified in the individual's Plan for Supports and related supporting documentation. Personal assistants' required training, as further detailed in the applicable provider manual, shall be met in one of the following ways:

- (1) Registration with the Board of Nursing as a certified nurse aide;
- (2) Graduation from an approved educational curriculum as listed by the Board of Nursing; or
- (3) Completion of the provider's educational curriculum, as conducted by a licensed RN who shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

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

10. Personal assistants to be paid by DMAS shall not be the parents of individuals enrolled in the waiver who are minor children or the individuals' spouses.

a. Payment shall not be made for services furnished by other family members living under the same roof as the individual enrolled in the waiver receiving services unless there is objective written documentation completed by the services facilitator, or the case manager when the individual does not select services facilitation, as to why there are no other providers available to render the services.

b. Family members who are approved to be reimbursed for providing this service shall meet the same qualifications as all other personal assistants.

11. Provider inability to render services and substitution of assistants (agency directed model).

a. When assistants are absent or otherwise unable to render scheduled supports to individuals enrolled in the waiver, the provider shall be responsible for ensuring that services continue to be provided to the affected individuals. The provider may either provide another assistant, obtain a substitute assistant from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another personal care or respite provider. The provider that has the service authorization to provide services to the individual enrolled in the waiver must contact the case manager to determine if additional, or modified, service authorization is necessary.

b. If no other provider is available who can supply a substitute assistant, the provider shall notify the individual and the individual's family/caregiver, as

appropriate, and the case manager so that the case manager may find another available provider of the individual's choice.

e. During temporary, short term lapses in coverage that are not expected to exceed approximately two weeks in duration, the following procedures shall apply:

- (1) The service authorized provider shall provide the supervision for the substitute assistant;
- (2) The provider of the substitute assistant shall send a copy of the assistant's daily documentation signed by the assistant, the individual, and the individual's family/caregiver, as appropriate, to the provider having the service authorization; and
- (3) The service authorized provider shall bill DMAS for services rendered by the substitute assistant.

d. If a provider secures a substitute assistant, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements. The two providers involved shall be responsible for negotiating the financial arrangements of paying the substitute assistant.

12. For the agency directed model, the personal assistant record shall contain:

- a. The specific services delivered to the individual enrolled in the waiver by the assistant, dated the day of service delivery, and the individual's responses;
- b. The assistant's arrival and departure times;
- c. The assistant's weekly comments or observations about the individual enrolled in the waiver to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and
- d. The assistant's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that services during that week have been rendered.

13. The records of individuals enrolled in the waiver who are receiving personal assistance services in a congregate residential setting (because skill building services are no longer appropriate or desired for the individual), must contain:

- a. The specific services delivered to the individual enrolled in the waiver, dated the day that such services were provided, the number of hours as outlined in the Plan for Supports, the individual's responses, and observations of the individual's physical and emotional condition; and

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b. At a minimum, monthly verification by the residential supervisor of the services and hours rendered and billed to DMAS.

14. For the consumer directed model, the services facilitator's record shall contain, at a minimum:

a. Documentation of all employer management training provided to the individual enrolled in the waiver and the EOR including the individual or the individual's family/caregiver, as appropriate, and EOR, as appropriate, receipt of training on their legal responsibilities for the accuracy and timeliness of the assistant's timesheets; and

b. All documents signed by the individual enrolled in the waiver and the EOR, as appropriate, which acknowledge the responsibilities as the employer.

J. Personal Emergency Response Systems. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, PERS providers shall also meet the following qualifications:

1. A PERS provider shall be either: (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.

2. 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.

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

4. 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.

5. 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.

6. 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.

7. 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.

8. A PERS provider shall maintain a data record for each PERS individual at no additional cost to DMAS or DBHDS. The record must document the following:

a. Delivery date and installation date of the PERS;

b. Individual or family/caregiver, as appropriate, signature verifying receipt of PERS device;

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

d. Updated and current individual responder and contact information, as provided by the individual, the individual's family/caregiver, or case manager; and

e. A case log documenting the individual's utilization of the system and contacts and communications with the individual, family/caregiver, case manager, and responders.

9. The PERS provider shall have back up monitoring capacity in case the primary system cannot handle incoming emergency signals.

10. 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.

11. A PERS provider shall instruct the individual, family/caregiver, and responders in the use of the PERS service.

12. The emergency response activator shall be able to be activated either by breath, by touch, or by some other means, and must be usable by individuals who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the back up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back up monitoring site without

the individual or family/caregiver resetting the system in the event it cannot get its signal accepted at the response center.

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

- a. A primary receiver and a back up receiver, which must be independent and interchangeable;
- b. A back-up information retrieval system;
- c. A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- d. A back-up power supply;
- e. A separate telephone service;
- f. A toll free number to be used by the PERS equipment in order to contact the primary or back up response center; and
- g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

14. The PERS provider shall maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment, emergency response protocols, and recordkeeping and reporting procedures.

15. The PERS provider shall document and furnish within 30 days of the action taken a written report to the case manager for each emergency signal that results in action being taken on behalf of the individual, excluding test signals or activations made in error.

K. Prevocational services. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-1040, prevocational providers shall also meet the following qualifications:

- 1. The provider of prevocational services shall be a vendor of either extended employment services, long term employment services, or supported employment services for DRS, or be licensed by DBHDS as a provider of day support services. Both licensee groups must also be enrolled with DMAS.

2. In addition to licensing requirements, prevocational staff shall also have training in the characteristics of ID and the appropriate interventions, skill building strategies, and support methods for individuals with ID and such functional limitations. All providers of prevocational services shall pass an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS' defined procedures. (See www.dbhds.virginia.gov for further information.)

3. Preparation and maintenance of documentation confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. An attendance log or similar document must be maintained that indicates the individual's name, date, type of services rendered, staff signature and date, and the number of service units delivered, in accordance with the DMAS fee schedule.

4. Preparation and maintenance of documentation indicating whether the services were center based or nonecenter based shall be included on the Plan for Supports.

5. In instances where prevocational staff may be required to ride with the individual enrolled in the waiver to and from prevocational services, the prevocational staff transportation time (actual time spent in transit) may be billed as prevocational services and documentation maintained, provided that billing for this time does not exceed 25% of the total time spent in prevocational services for that day.

6. If intensive prevocational services are requested, documentation indicating the specific supports and the reasons they are needed shall be included in the Plan for Supports. For ongoing intensive prevocational services, there shall be specific documentation of the ongoing needs and associated staff supports.

7. Preparation and maintenance of documentation indicating that prevocational services are not available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA).

L. Residential support services.

1. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040 and in order to be reimbursed by DMAS for rendering these services, the provider of residential services shall have the appropriate DBHDS residential license (12VAC35-105).

2. Residential support services may also be provided in adult foster care homes approved by local department of social services' offices pursuant to 22VAC40-771-20.

3. In addition to licensing requirements, provider personnel rendering residential support services shall participate in

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training in the characteristics of ID and appropriate interventions, skill building strategies, and support methods for individuals who have diagnoses of ID and functional limitations. See www.dbhds.virginia.gov for information about such training. All providers of residential support services must pass an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS' defined procedures.

4. Provider professional documentation shall confirm the individual's participation in the services and provide specific information regarding the individual's responses to various settings and supports as set out in the Plan for Supports.

M. Respite services (both consumer directed and agency directed models). In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, respite services providers shall meet additional provider requirements:

1. For the agency directed model, services shall be provided by an enrolled DMAS respite care provider or by a residential services provider licensed by the DBHDS that is also enrolled by DMAS. In addition, respite services may be provided by a DBHDS licensed respite services provider or a local department of social services approved foster care home for children or by an adult foster care provider that is also enrolled by DMAS.

2. For the CD model, services shall meet the requirements found in Services Facilitation, 12VAC30-120-1020.

3. For DBHDS licensed residential or respite services providers, a residential or respite supervisor shall provide ongoing supervision of all respite assistants.

4. For DMAS enrolled respite care providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all assistants. The supervising RN or LPN must have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/ID, or nursing facility.

5. For agency directed services, the supervisor, or for CD services the services facilitator, shall make a home visit to conduct an initial assessment prior to the start of services for all individuals enrolled in the waiver requesting respite services. The supervisor or services facilitator, as appropriate, shall also perform any subsequent reassessments or changes to the Plan for Supports.

6. The supervisor or services facilitator, as appropriate, shall make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits shall be every 30 to 90 days under the agency directed model and semi annually

(every six months) under the CD model of services, depending on the individual's needs.

a. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator shall conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite service authorization period. The supervisor or services facilitator, as appropriate, shall review the use of respite services either every six months or upon the use of 240 respite service hours, whichever comes first.

b. When respite services are routine in nature, that is occurring with a scheduled regularity for specific periods of time, and offered in conjunction with personal assistance, the supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor or services facilitator, as appropriate, shall document supervision of respite services separately. For this purpose, the same individual record shall be used with a separate section for respite services documentation.

7. Based on continuing evaluations of the assistant's performance and individual's needs, the supervisor (for agency directed services) or the individual or the EOR (for the CD model) shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

8. Qualifications for respite assistants. The assistant shall:

a. Be 18 years of age or older and possess a valid social security number that has been issued by the Social Security Administration to the person who is to function as the respite assistant;

b. Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills; and

c. Have the required skills to perform services as specified in the individual's Plan for Supports and shall be physically able to perform the tasks required by the individual enrolled in the waiver.

9. Additional requirements for DMAS enrolled (agency directed) respite care providers.

a. Respite assistants shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual/developmental disabilities, as ensured by the provider prior to being assigned to support an individual, and have the required skills and training to perform the services as specified in the individual's Plan for Supports and related supporting documentation. Respite assistants' required training, as further detailed in the applicable provider manual, shall be met in one of the following ways:

~~(1) Registration with the Board of Nursing as a certified nurse aide;~~

~~(2) Graduation from an approved educational curriculum as listed by the Board of Nursing; or~~

~~(3) Completion of the provider's educational curriculum, as taught by an RN who shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/ID, or nursing facility.~~

~~b. Assistants shall have a satisfactory work record, as evidenced by two references from prior job experiences including no evidence of possible abuse, neglect, or exploitation of any person regardless of age or disability.~~

~~10. Additional requirements for respite assistants for the CD option. The assistant shall:~~

~~a. Be willing to attend training at the individual's and the individual family/caregiver's, as appropriate, request;~~

~~b. Understand and agree to comply with the DMAS' ID Waiver requirements as contained in 12VAC30-120-1000 et seq.; and~~

~~c. Receive an annual tuberculosis screening.~~

~~11. Assistants to be paid by DMAS shall not be the parents of individuals enrolled in the waiver who are minor children or the individuals' spouses. Payment shall not be made for services furnished by other family members living under the same roof as the individual who is receiving services unless there is objective written documentation completed by the services facilitator, or the case manager when the individual does not select services facilitation, as to why there are no other providers available to render the services required by the individual. Family members who are approved to be reimbursed for providing this service shall meet the same qualifications as all other respite assistants.~~

~~12. Provider inability to render services and substitution of assistants (agency directed model).~~

~~a. When assistants are absent or otherwise unable to render scheduled supports to individuals enrolled in the waiver, the provider shall be responsible for ensuring that services continue to be provided to individuals. The provider may either provide another assistant, obtain a substitute assistant from another provider if the lapse in coverage is expected to be less than two weeks in duration, or transfer the individual's services to another respite care provider. The provider that has the service authorization to provide services to the individual enrolled in the waiver must contact the case manager to determine if additional, or modified, service authorization is necessary.~~

~~b. If no other provider is available who can supply a substitute assistant, the provider shall notify the individual and the individual's family/caregiver, as appropriate, and the case manager so that the case~~

~~manager may find another available provider of the individual's choice.~~

~~e. During temporary, short term lapses in coverage not to exceed two weeks in duration, the following procedures shall apply:~~

~~(1) The service authorized provider shall provide the supervision for the substitute assistant;~~

~~(2) The provider of the substitute assistant shall send a copy of the assistant's daily documentation signed by the assistant, the individual and the individual's family/caregiver, as appropriate, to the provider having the service authorization; and~~

~~(3) The service authorized provider shall bill DMAS for services rendered by the substitute assistant.~~

~~d. If a provider secures a substitute assistant, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements. The two providers involved shall be responsible for negotiating the financial arrangements of paying the substitute assistant.~~

~~13. For the agency directed model, the assistant record shall contain:~~

~~a. The specific services delivered to the individual enrolled in the waiver by the assistant, dated the day of service delivery, and the individual's responses;~~

~~b. The assistant's arrival and departure times;~~

~~e. The assistant's weekly comments or observations about the individual enrolled in the waiver to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and~~

~~d. The assistant's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that services during that week have been rendered.~~

~~N. Services facilitation and consumer directed model of service delivery.~~

~~1. If the services facilitator is not an RN, the services facilitator shall inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed by the individual.~~

~~2. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the services facilitator shall have sufficient resources to perform the required activities, including the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. To be enrolled, the services facilitator shall also~~

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meet the combination of work experience and relevant education set out in this subsection that indicate the possession of the specific knowledge, skills, and abilities to perform this function. The services facilitator shall maintain a record of each individual containing elements as set out in this section.

a. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth or hold multi state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with individuals with intellectual disability or individuals with other developmental disabilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

(1) Knowledge of:

- (a) Types of functional limitations and health problems that may occur in individuals with intellectual disability or individuals with other developmental disabilities, as well as strategies to reduce limitations and health problems;
- (b) Physical assistance that may be required by individuals with intellectual disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
- (c) Equipment and environmental modifications that may be required by individuals with intellectual disabilities that reduce the need for human help and improve safety;
- (d) Various long term care program requirements, including nursing home and ICF/ID placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;
- (e) ID Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;
- (f) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;
- (g) Interviewing techniques;
- (h) The individual's right to make decisions about, direct the provisions of, and control his consumer directed personal assistance, companion and respite services, including hiring, training, managing, approving timesheets, and firing an assistant/companion;
- (i) The principles of human behavior and interpersonal relationships; and

(j) General principles of record documentation.

(2) Skills in:

- (a) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;
- (b) Assessing, supporting, observing, recording, and reporting behaviors;
- (c) Identifying, developing, or providing services to individuals with intellectual disabilities; and
- (d) Identifying services within the established services system to meet the individual's needs.

(3) Abilities to:

- (a) Report findings of the assessment or onsite visit, either in writing or an alternative format, for individuals who have visual impairments;
- (b) Demonstrate a positive regard for individuals and their families;
- (c) Be persistent and remain objective;
- (d) Work independently, performing position duties under general supervision;
- (e) Communicate effectively, orally and in writing; and
- (f) Develop a rapport and communicate with individuals of diverse cultural backgrounds.

3. The services facilitator's record shall contain:

- a. Documentation of all employer management training provided to the individual enrolled in the waiver and the EOR, as appropriate, including the individual's or the EOR's, as appropriate, receipt of training on their responsibility for the accuracy and timeliness of the assistant's timesheets; and
- b. All documents signed by the individual enrolled in the waiver or the EOR, as appropriate, which acknowledge their legal responsibilities as the employer.

O. Skilled nursing services. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, participating skilled nursing providers shall meet the following qualifications:

- 1. Skilled nursing services shall be provided by either a DMAS enrolled home health provider, or by a licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN who shall be contracted with or employed by DBHDS licensed day support, respite, or residential providers.
- 2. Skilled nursing services providers shall not be the parents (natural, adoptive, or foster) of individuals enrolled in the waiver who are minor children or the individual's spouse. Payment shall not be made for services furnished by other family members who are living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no

other providers available to provide the care. Other family members who are approved to provide skilled nursing services must meet the same skilled nursing provider requirements as all other licensed providers.

3. Foster care providers shall not be the skilled nursing services providers for the same individuals for whom they provide foster care.

4. Skilled nursing hours shall not be reimbursed while the individual enrolled in the waiver is receiving emergency care or is an inpatient in an acute care hospital or during emergency transport of the individual to such facilities. The attending RN or LPN shall not transport the individual enrolled in the waiver to such facilities.

5. Skilled nursing services may be ordered but shall not be provided simultaneously with respite or personal assistance services.

6. Reimbursement for skilled nursing services shall not be made for services that may be delivered prior to the attending physician's dated signature on the individual's support plan in the form of the physician's order.

7. DMAS shall not reimburse for skilled nursing services that may be rendered simultaneously through the Medicaid EPSDT benefit and the Medicare home health skilled nursing service benefit.

8. Required documentation. The provider shall maintain a record, for each individual enrolled in the waiver whom he serves, that contains:

a. A Plan for Supports that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) Services to be rendered and the frequency of services to accomplish the above desired outcomes and support activities;

(3) The estimated duration of the individual's needs for services; and

(4) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;

b. Documentation of all training, including the dates and times, provided to family/caregivers or staff, or both, including the person or persons being trained and the content of the training. Training of professional staff shall be consistent with the Nurse Practice Act;

c. Documentation of the physician's determination of medical necessity prior to services being rendered;

d. Documentation of nursing license/qualifications of providers;

e. Documentation indicating the dates and times of nursing services that are provided and the amount and type of service;

f. Documentation that the Plan for Supports was reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the CSB/BHA case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual and the family/caregiver, as appropriate; and

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

P. Supported employment services. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, supported employment provider qualifications shall include:

1. Group and individual supported employment shall be provided only by agencies that are DRS vendors of supported employment services;

2. Documentation indicating that supported employment services are not available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA); and

3. In instances where supported employment staff are required to ride with the individual enrolled in the waiver to and from supported employment activities, the supported employment staff's transportation time (actual transport time) may be billed as supported employment, provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day.

Q. Therapeutic consultation. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-1040, professionals rendering therapeutic consultation services shall meet all applicable state or national licensure, endorsement or certification requirements. The following documentation shall be required for therapeutic consultation:

1. A Plan for Supports, that contains at a minimum, the following elements:

a. Identifying information;

b. Desired outcomes, support activities, and time frames; and

c. Specific consultation activities.

2. A written support plan detailing the recommended interventions or support strategies for providers and

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family/caregivers to better support the individual enrolled in the waiver in the service.

~~3. Ongoing documentation of rendered consultative services which may be in the form of contact by contact or monthly notes, which must be signed and dated, that identify each contact, what was accomplished, the professional who made the contact and rendered the service.~~

~~4. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the case manager. If the consultation service extends beyond one year or when there are changes to the Plan for Supports, the Plan shall be reviewed by the provider with the individual and family/caregiver, as appropriate. The Plan for Supports shall be agreed to by the individual and family/caregiver, as appropriate, and the case manager and shall be submitted to the case manager. All changes to the Plan for Supports shall be reviewed with and agreed to by the individual and the individual's family/caregiver, as appropriate.~~

~~5. A final disposition summary must be forwarded to the case manager within 30 days following the end of this service.~~

~~R. Transition services. Providers shall be enrolled as a Medicaid provider for case management. DMAS or the DMAS designated agent shall reimburse for the purchase of appropriate transition goods or services on behalf of the individual as set out in 12VAC30-120-1020 and 12VAC30-120-2010.~~

~~S. Case manager's responsibilities for the Medicaid Long-Term Care Communication Form (DMAS 225).~~

~~1. When any of the following circumstances occur, it shall be the responsibility of the case management provider to notify DBHDS and the local department of social services, in writing using the DMAS 225 form, and the responsibility of DBHDS to update DMAS, as requested:~~

~~a. Home and community based waiver services are implemented.~~

~~b. An individual enrolled in the waiver dies.~~

~~c. An individual enrolled in the waiver is discharged from all ID Waiver services.~~

~~d. Any other circumstances (including hospitalization) that cause home and community based waiver services to cease or be interrupted for more than 30 days.~~

~~e. A selection by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate, of an alternative community services board/behavioral health authority that provides case management services.~~

~~2. Documentation requirements. The case manager shall maintain the following documentation for review by~~

~~DMAS for a period of not less than six years from each individual's last date of service:~~

~~a. The initial comprehensive assessment, subsequent updated assessments, and all Individual Support Plans completed for the individual;~~

~~b. All Plans for Support from every provider rendering waiver services to the individual;~~

~~c. All supporting documentation related to any change in the Individual Support Plans;~~

~~d. All related communication with the individual and the individual's family/caregiver, as appropriate, consultants, providers, DBHDS, DMAS, DRS, local departments of social services, or other related parties;~~

~~e. An ongoing log that documents all contacts made by the case manager related to the individual enrolled in the waiver and the individual's family/caregiver, as appropriate; and~~

~~f. When a service provider or consumer directed personal or respite assistant or companion is designated by the case manager to collect the patient pay amount, a copy of the case manager's written designation, as specified in 12VAC30-120-1010 D 5, and documentation of monthly monitoring of DMAS designated system.~~

~~T. The service providers shall maintain, for a period of not less than six years from the individual's last date of service, documentation necessary to support services billed. Review of individual specific documentation shall be conducted by DMAS staff. This documentation shall contain, up to and including the last date of service, all of the following:~~

~~1. All assessments and reassessments.~~

~~2. All Plans for Support developed for that individual and the written reviews.~~

~~3. Documentation of the date services were rendered and the amount and type of services rendered.~~

~~4. Appropriate data, contact notes, or progress notes reflecting an individual's status and, as appropriate, progress or lack of progress toward the outcomes on the Plans for Support.~~

~~5. Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.~~

~~6. Documentation shall be filed in the individual's record upon the documentation's completion but not later than two weeks from the date of the document's preparation. Documentation for an individual's record shall not be created or modified once a review or audit of that individual enrolled in the waiver has been initiated by either DBHDS or DMAS.~~

12VAC30-120-1061. Provider requirements for assistive technology (AT), electronic home based services (EHBS), environmental modifications (EM), personal emergency response systems (PERS).

A. The required documentation for assistive technology, environmental modifications (EM), electronic home-based supports (EHBS), and personal emergency response systems (PERS) shall be as follows:

1. The appropriate service authorization to be completed by the support coordinator/case manager may serve as the Plan for Supports for the provision of AT, EM, EHBS, and PERS services. A rehabilitation engineer may be involved for AT, EHBS, PERS, or EM services if disability expertise is required that a general contractor may not have. The Plan for Supports and service authorization shall include justification and explanation if a rehabilitation engineer is needed. The service authorization request shall be submitted to the state-designated agency or its designee in order for service authorization to occur;
2. For these services, written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as durable medical equipment (DME) and supplies, and that it is not available from a DME provider;
3. Documentation of the recommendation for the item by an independent professional consultant;
4. Documentation of the date services are rendered and the amount of service that is needed;
5. Any other relevant information regarding the device or modification;
6. Documentation in the support coordination/case management record of notification by the designated individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item; and
7. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

B. Assistive technology (AT). In addition to meeting the service coverage requirements in 12VAC30-120-1021 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., AT shall be provided by DMAS-enrolled DME providers or DMAS-enrolled CSBs/BHAs with a signed, current waiver provider agreement with DMAS to provide AT. DME shall be provided in accordance with 12VAC30-50-165.

1. Independent assessments for AT shall be conducted by independent professional consultants. Independent, professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers.

2. Providers that supply AT for an individual shall not perform assessment/consultation, write specifications, or inspect the AT for that individual. Providers of services shall not be spouses or parents (natural, adoptive, foster, or step-parent)/caregivers of the individual.

3. AT shall be delivered within the ISP year, or within a year from the start date of the authorization.

4. If required, a rehabilitation engineer or certified rehabilitation specialist may be utilized if (i) the assistive technology will be initiated in combination with environmental modifications involving systems that are not designed to be compatible or (ii) an existing device must be modified or a specialized device must be designed and fabricated.

C. Electronic home-based supports (EHBS).

1. Providers of this service shall have a current, signed participation agreement with DMAS. Providers as designated on this agreement shall render these services directly and shall bill DMAS directly for Medicaid reimbursement. These providers shall be one of the following:

- a. A licensed personal care agency;
- b. A durable medical equipment provider;
- c. A CSB/BHA;
- d. A center for independent living;
- e. A licensed home health provider; or
- f. An EHBS manufacturer that has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, service calls and monitoring services);

2. The EHBS provider shall have the primary responsibility to furnish, install, maintain, test, and service the equipment, as may be required, to keep it fully operational.

3. The EHBS provider shall properly install all authorized equipment and shall furnish all supplies necessary to ensure that the system is properly installed and working.

4. The provider shall replace or repair the device or system within 24 hours of the individual's or family/caregiver's notification of a malfunction of the unit or system.

5. The provider of ongoing electronic monitoring systems shall provide an emergency response center with fully trained operators who are capable of receiving signals for help from an individual's EHBS 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 EHBS service individual needs emergency help.

6. The EHBS provider shall install, test, and demonstrate to the individual and family/caregiver, as appropriate, the unit

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or system before submitting his claim for services to DMAS.

7. An EHBS provider shall maintain a data record for each individual receiving EHBS at no additional cost to DMAS. The record shall document all of the following:

- a. Delivery date and installation date of the EHBS;
- b. The signature of the individual or his family/caregiver, as appropriate, verifying receipt of the EHBS device;
- c. Verification by a test that the EHBS device is operational, monthly or more frequently as needed;
- d. Updated and current individual responder and contact information, as provided by the individual or the individual's care provider or support coordinator/case manager; and
- e. A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, support coordinator/case manager, or responder.

D. Environmental modifications. In addition to meeting the service coverage requirements in 12VAC30-120-1025 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., environmental modifications shall be provided in accordance with all applicable federal, state, or local building codes and laws by CSBs/BHAs contractors or DMAS-enrolled providers.

E. Personal emergency response systems (PERS). In addition to meeting the service coverage requirements in 12VAC30-120-1030 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., PERS providers shall also meet the requirements in subdivision 16 of 12VAC30-120-1560.

12VAC30-120-1063. Provider requirements for crisis support services (including crisis stabilization); center-based crisis supports; community-based crisis supports.

A. Crisis support services. In addition to the service coverage requirements in 12VAC30-120-1024 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., the following crisis support provider qualifications shall apply:

1. Documentation of providers' qualifications shall be maintained for review by DBHDS and DMAS staff or the DMAS designated agent.
2. A Plan for Supports shall be developed (or revised, in case of a request for extension) and submitted to the support coordinator/case manager for authorization within 72 hours of the requested start date and face-to-face assessment or reassessment for authorization.
3. Provider documentation requirements shall be the same as those set forth in 12VAC30-120-1024 E 5.

4. Required documentation in the individual's record. The provider shall maintain a record regarding each individual enrolled in the waiver who is receiving crisis support services. At a minimum, the record shall contain the following:

- a. Documentation of the face-to-face assessment and any reassessments completed by a QDDP;
- b. A Plan for Supports that contains, at a minimum, the following elements:
 - (1) The individual's strengths, desired outcomes, and required or desired supports;
 - (2) Services to be rendered and the frequency of services to accomplish these desired outcomes and support activities;
 - (3) A timetable for the accomplishment of the individual's desired outcomes and support activities;
 - (4) The estimated duration of the individual's needs for services; and
 - (5) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

B. Center-based crisis supports. Provider documentation requirements shall be the same as those set forth in 12VAC30-120-1024 E 5.

C. Community-based crisis supports.

1. Provider documentation requirements shall be the same as those set forth in 12VAC30-120-1024 E 5.

2. Required documentation in the individual's record. The provider shall maintain a record regarding each individual enrolled in the waiver who is receiving community-based crisis support services. At a minimum, the record shall contain the following:

- a. Documentation of the face-to-face assessment and any reassessments completed by a QDDP;
- b. A plan for supports that contains, at a minimum, the following elements:
 - (1) The individual's strengths, desired outcomes, required or desired supports;
 - (2) Services to be rendered and the frequency of services to accomplish these desired outcomes and support activities;
 - (3) A timetable for the accomplishment of the individual's desired outcomes and support activities;
 - (4) The estimated duration of the individual's needs for services; and
 - (5) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

12VAC30-120-1064. Provider requirements for group home residential services; sponsored residential; supported living residential.

A. The required documentation for group home residential, sponsored residential, and supported living residential shall be as follows:

1. A completed copy of the DBHDS-approved SIS[®] assessment form.
2. The provider's Plan for Supports containing, at a minimum, the following elements:
 - a. The individual's strengths, desired outcomes, required or desired supports or both, and skill-building needs;
 - b. The individual's support activities to meet the identified outcomes;
 - c. The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
 - d. A timetable for the accomplishment of the individual's desired outcomes and support activities;
 - e. The estimated duration of the individual's needs for services; and
 - f. The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

3. Documentation indicating that the Plan for Supports desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review shall be submitted to the support coordinator/case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.

4. All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator/case manager, DMAS, and DBHDS.

5. Written documentation of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

B. Group home residential services. In addition to meeting the service coverage requirements in 12VAC30-120-1027 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., group home residential providers shall meet the following requirements:

1. The provider of group home residential services for adults (ages 18 years or older) shall be licensed by DBHDS as a provider of group home residential services or a provider approved by the local department of social services as an adult foster care provider (12VAC35-105-20). Providers of group home residential services for

children (ages up to the 18th birthday) shall be licensed by DBHDS as children's residential providers.

2. Provider documentation shall confirm the individual's days in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. This documentation shall be available in a daily progress note. Data shall be collected as described in the Plan for Supports and summarized, and then relevant changes shall be added to the supporting documentation.

3. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and this written review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.

4. These services shall include a skills development component along with the provision of supports, as needed.

C. Supported living residential services. Service providers shall be licensed by DBHDS as providers of supervised living residential services.

12VAC30-120-1065. Provider requirements for community engagement; community coaching.

A. Community engagement. In addition to meeting the service coverage requirements in 12VAC30-120-1022 A and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., community engagement providers shall meet the following requirements:

1. Community engagement service providers shall be licensed by DBHDS as providers of non-center-based day support services.

2. Such providers shall have a current, signed provider participation agreement with DMAS in order to render these services for Medicaid reimbursement. The provider that is designated in this agreement shall render the services directly and shall directly bill DMAS for reimbursement.

3. Prior to rendering these services, community engagement providers shall also ensure that persons rendering 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.

- a. In addition to receiving such training, these persons shall pass, with at least a score of 80%, an objective, standardized test of knowledge, skills, and abilities in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations.

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b. This required test shall be administered according to DBHDS defined procedures.

c. The provider shall maintain documentation of this training and acceptable testing results on all persons employed to render community engagement services. Such documentation shall be provided to DMAS and DBHDS upon request.

B. Community coaching provider requirements.

1. Community coaching service providers shall be licensed by DBHDS as a provider of day support services.

2. Providers shall have a current, signed provider participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement shall directly provide the services and bill DMAS for reimbursement.

3. Providers shall 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, with a score of at least 80%, of skills, knowledge, and abilities approved by DBHDS that shall be administered according to DBHDS defined procedures.

4. The provider shall maintain documentation of the training and acceptable testing results on all persons employed to render community coaching services. Such documentation shall be provided to DMAS and DBHDS upon request.

C. Community guide. (Reserved.)

12VAC30-120-1066. Provider requirements for supported employment (individual & group); workplace assistance.

A. Group supported employment services. In addition to meeting the service coverage requirements in 12VAC30-120-1035 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., group supported employment providers shall meet the following requirements:

1. Providers of group-supported employment services shall be DARS-contracted providers of supported employment services. DARS shall verify that these providers meet criteria to be providers through a DARS-recognized accrediting body. DARS shall provide the documentation of this accreditation verification to DMAS and DBHDS upon request.

2. Providers shall maintain their accreditation in order to continue to receive Medicaid reimbursement. Providers that lose their accreditation, regardless of the reason, shall not be eligible to receive Medicaid reimbursement and shall have their provider agreement terminated by DMAS. Reimbursements made to such providers after the date of

the loss of the accreditation shall be subject to recovery by DMAS.

3. Provider documentation shall confirm the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the plan for supports. Assessment results shall be available in at least a daily note or a weekly summary. Data shall be collected as described in the Plan for Supports, reviewed, summarized, and included in the regular supporting documentation.

4. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and this written person-centered review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.

5. Providers of group-supported employment shall submit employment-related data to DBHDS as requested and no more than quarterly.

B. Individual supported employment services. In addition to meeting the service coverage requirements in 12VAC30-120-1035 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., individual supported employment providers shall meet the following additional requirements:

1. Individual supported employment services providers shall have a current, signed provider participation agreement with DMAS. The provider designated in this agreement shall directly coordinate the services and directly bill DMAS for reimbursement.

2. Providers of individual supported employment services shall be providers of supported employment services with DARS. DARS shall verify that these providers meet criteria to be providers through a recognized accrediting body. DARS shall provide the documentation of this accreditation verification to DMAS and DBHDS upon request.

3. Providers shall maintain their accreditation in order to continue to receive Medicaid reimbursement. Providers that lose their accreditation, regardless of the reason, shall not be eligible to receive Medicaid reimbursement and shall have their provider agreement terminated by DMAS. Reimbursements made to such providers after the date of the loss of the accreditation shall be subject to recovery by DMAS. Providers whose accreditation is restored shall be permitted to re-enroll with DMAS upon presentation of accreditation documentation and a new signed provider participation agreement.

4. Provider documentation shall confirm the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the plan for supports. Assessment results shall be available in at least a daily note

or a weekly summary. Data shall be collected as described in the plan for supports, reviewed, summarized, and included in the regular supporting documentation.

5. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and this written person-centered review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.

6. Providers of group-supported employment shall submit employment-related data to DBHDS as requested and no more than quarterly.

C. Workplace assistance. In addition to meeting the service coverage requirements in 12VAC30-120-1039 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., workplace assistance services providers shall meet the following requirements:

1. These providers shall be either:

- a. Providers of supported employment services with DARS; or
- b. Be licensed by DBHDS as a provider of non-center-based day support services.

2. Prior to seeking reimbursement for this service from DMAS, these providers shall ensure that staff persons providing workplace assistance services have completed training regarding the principles of supported employment. The documentation of the completion of this training shall be maintained by the provider and shall be provided to DMAS and DBHDS upon request.

3. The direct support professional providing workplace assistance services shall coordinate his service provision with the job coach, if there is one working with the individual, who may be providing individual supported employment services to the individual being supported.

12VAC30-120-1067. Nursing services (skilled and private duty).

A. Skilled nursing services. In addition to meeting the service requirements in 12VAC30-120-1031 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., participating skilled nursing providers shall meet the following requirements:

1. Required documentation. The provider shall maintain a record, for each individual enrolled in the waiver whom he serves, that contains:

- a. A Plan for Supports that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, and required or desired supports;

(2) Services to be rendered and the frequency of services to accomplish the desired outcomes and support activities;

(3) The estimated duration of the individual's needs for services; and

(4) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;

b. Documentation of all training, including the dates and times, provided to family/caregivers or staff, or both, including the person or persons being trained and the content of the training. Training of professional staff shall be consistent with the Regulations Governing the Practice of Nursing (18VAC90-20);

c. Documentation of the physician's determination of medical necessity prior to services being rendered;

d. Documentation of nursing license or qualifications of providers;

e. Documentation indicating the dates and times of nursing services that are provided and the amount and type of service;

f. Documentation that the Plan for Supports was reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the support coordinator/case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual and the family/caregiver, as appropriate; and

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

2. Providers shall either employ or subcontract with nurses who are currently licensed as either RNs or LPNs under Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, or who hold a current multistate licensure privilege to practice nursing in the Commonwealth.

3. Skilled nursing services may be provided by either (i) a licensed registered nurse (RN) or licensed practical nurse (LPN), who is under the supervision of a licensed RN, employed by a DMAS-enrolled home health provider or (ii) a licensed RN or LPN, who is under the supervision of a licensed RN, contracted with or employed by a DBHDS-licensed day support, respite, or residential services provider.

B. Private duty nursing services provider requirements. In addition to meeting the service coverage requirements in 12VAC30-120-1031 B and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq.,

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participating private duty nursing providers shall meet the following requirements:

1. If the provider designated in the participation agreement employs LPNs to render direct care, then the provider shall also employ an RN, or be an RN himself, in order to supervise the LPNs.

2. Private duty nursing services may be provided by either (i) a licensed registered nurse (RN) or licensed practical nurse (LPN), who is under the supervision of a licensed RN, employed by a DMAS-enrolled home health provider; or (ii) a licensed RN or LPN, who is under the supervision of a licensed RN, contracted with or employed by a DBHDS-licensed day support, respite, or residential services provider.

3. Both RNs and LPNs providing private duty nursing services shall have current licenses issued by the Virginia Board of Nursing or current multistate licensure privileges to practice nursing in the Commonwealth.

12VAC30-120-1068. Provider requirements for benefits planning; nonmedical transportation; therapeutic consultation; transition services.

A. Benefits planning. (Reserved.)

B. Nonmedical transportation. (Reserved.)

C. Therapeutic consultation. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-1037 and 12VAC30-120-501 et seq., professionals rendering therapeutic consultation services, including behavior consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation services shall be rehabilitation engineers or certified rehabilitation specialists.

1. Supporting documentation for therapeutic consultation. The following information shall be required in the supporting documentation:

a. A Plan for Supports, that contains at a minimum, the following elements:

(1) Identifying information;

(2) Desired outcomes, support activities, and timeframes; and

(3) Specific consultation activities.

b. A written support plan detailing the recommended interventions or support strategies for providers and family/caregivers to better support the individual enrolled in the waiver in the service.

c. Ongoing documentation of rendered consultative services that may be in the form of contact-by-contact or monthly notes, which must be signed and dated, that identify each contact, what was accomplished, and the professional who made the contact and rendered the service.

d. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the support coordinator/case manager. If the consultation service extends beyond one year or when there are changes to the Plan for Supports, the plan shall be reviewed by the provider with the individual and family/caregiver, as appropriate. The Plan for Supports shall be agreed to by the individual and family/caregiver, as appropriate and the support coordinator/case manager and shall be submitted to the support coordinator/case manager. All changes to the Plan for Supports shall be reviewed with and agreed to by the individual and the individual's family/caregiver, as appropriate.

e. A final disposition summary shall be forwarded to the support coordinator/case manager within 30 days following the end of this service and shall include:

(1) Strategies utilized;

(2) Objectives met;

(3) Unresolved issues; and

(4) Consultant recommendations.

2. Professional qualifications.

a. Providers rendering therapeutic consultation services shall meet all applicable state or federal licensure, endorsement, or certification requirements.

b. Behavior consultation shall only be provided by (i) a board-certified behavioral analyst or a board-certified associate behavior analyst or (ii) a positive behavioral supports facilitator endorsed by a recognized Positive Behavioral Supports Organization or who meets the criteria for psychology consultation.

c. Psychology consultation shall only be provided by the following individuals licensed in the Commonwealth of Virginia: (i) a psychologist; (ii) a licensed professional counselor; (iii) a licensed clinical social worker; (iv) psychiatric clinical nurse specialist; or (v) a psychiatrist.

d. Speech consultation shall only be provided by a speech-language pathologist who is licensed by the Commonwealth of Virginia.

e. Occupational therapy consultation shall only be provided by an occupational therapist who is licensed by the Commonwealth of Virginia.

f. Physical therapy consultation shall only be provided by a physical therapist who is licensed by the Commonwealth of Virginia.

g. Therapeutic recreation consultation shall only be provided by a therapeutic recreation specialist who is certified by the National Council for Therapeutic Recreation Certification.

h. Rehabilitation consultation shall only be provided by a rehabilitation engineer or certified rehabilitation specialist.

D. Transition services. Provider requirements shall be the same as those set out in 12VAC30-120-2000 and 12VAC30-120-2010.

12VAC30-120-1069. Provider requirements for shared living supports.

In addition to meeting the service coverage requirements in 12VAC30-120-1034 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-501 et seq., participating shared living support providers shall meet the following qualifications and requirements:

1. Shared living support administrative providers shall be licensed by DBHDS to provide services to individuals with DD and shall manage the administrative aspects of this service, including roommate matching as needed, background checks, training, periodic onsite monitoring, and disbursing funds to the individual. This administrative provider shall be reimbursed a flat fee payment for the completion of these duties. DMAS may audit such provider's records for compliance with these requirements.
2. Administrative providers shall have a current, signed participation agreement with DMAS in order to provide these services. The provider designated in this agreement shall coordinate these services and submit claims directly to DMAS for reimbursement.
3. Administrative providers shall ensure that there is a back-up plan in the event that the live-in roommate is unable to provide the agreed to supports.
4. Documentation of the actual amount of rent shall be submitted simultaneously with the request for service authorization.
5. Reimbursement for shared living support services shall be based upon compliance with DMAS submission requirements for claims and supporting documentation as may be required as proof of service delivery. Claims that are not supported by the required documentation shall be subject to recovery by DMAS of any expenditures that may have been made.
6. For quality management review (QMR) and utilization review purposes, the administrative provider shall be required to maintain and present to DMAS, as requested, an agreement that identifies what supports in the individual's Plan for Supports the roommate will provide, and this agreement shall be signed by the individual and the roommate. The individual's support coordinator/case manager shall retain a copy of this signed, executed agreement in his file for the particular individual.
7. The administrative provider shall ensure that there is a back-up plan in place in the event that the roommate is unable or unavailable to provide supports. The administrative provider shall maintain documentation of the actual rent, food, and utilities costs and submit it with the service authorization request for shared living services.

8. The administrative provider shall submit monthly claims for reimbursement based upon the amount determined through the service authorization process.

9. Weekly summaries of supports provided by the roommate and signed by the roommate shall be maintained by the administrative provider.

12VAC30-120-1070. Payment for services.

A. All ~~residential support~~ shared living, group home residential, sponsored residential, supported living residential, in-home support, group day support, community engagement, community coaching, personal assistance (both agency directed and consumer directed), respite (both agency directed and consumer directed), skilled nursing, private duty nursing, therapeutic consultation, crisis stabilization support, ~~prevocational~~, center-based crisis support, community-based crisis support, PERS, companion (both agency directed and consumer directed), consumer-directed services facilitation, workplace assistance, and transition services provided in this waiver shall be reimbursed consistent with the agency's service limits and payment amounts as set out in the fee schedule.

B. Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same ~~procedures~~ services. Reimbursement rates for group supported employment shall be as set by DMAS.

C. All AT and EM covered procedure codes provided in the ~~ID Waiver~~ CL Waiver shall be reimbursed as a service limit of one. The maximum Medicaid funded expenditure per individual for all ~~AT/EM~~ AT and EM covered procedure codes (~~combined total of AT/EM items and labor related to these items~~) shall be \$5,000 each for AT and \$5000 for EM per calendar year. No additional mark-ups, such as in the durable medical equipment rules, shall be permitted.

D. Duplication of services.

1. DMAS shall not duplicate reimbursement for services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, the Virginians with Disabilities Act, or any other applicable statute.
2. Payment for services under the Plan for Supports shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
3. Payment for services under the Plan for Supports shall not be made for services that are duplicative of each other.
4. Payments for services shall only be provided as set out in the individuals' ~~Plans for Supports~~ Individual Support Plans.

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~~12VAC30-120-1080. Utilization review; level of care reviews. (Repealed.)~~

~~A. Reevaluation of service need and case manager review. Case managers shall complete reviews and updates of the Individual Support Plan and level of care as specified in 12VAC30-120-1020. Providers shall meet the documentation requirements as specified in 12VAC30-120-1040.~~

~~B. Quality management reviews (QMR) shall be performed by DMAS Division of Long Term Care Services or its designated contractor. Utilization review of rendered services shall be conducted by DMAS Division of Program Integrity (PI) or its designated contractor.~~

~~C. Providers who are determined during QMRs to not be in compliance with the requirements of these regulations may be requested to provide a corrective action plan. DMAS shall follow up with such providers on subsequent QMRs to evaluate compliance with their corrective action plans. Providers failing to comply with their corrective action plans shall be referred to Program Integrity for further review and possible sanctions.~~

~~D. Providers who are determined during PI utilization reviews to not be in compliance with these regulations may have their reimbursement retracted or other action pursuant to 12VAC30-120-1040 and 12VAC30-120-1060.~~

~~E. Individuals enrolled in the waiver who no longer meet the ID Waiver services and level of care criteria shall be informed of the termination of services and shall be afforded their right to appeal pursuant to 12VAC30-120-1090.~~

~~12VAC30-120-1088. Waiver waiting list. (Repealed.)~~

~~A. This waiver shall have both urgent and nonurgent waiting lists.~~

~~B. Urgent waiting list criteria. When a slot becomes available, the CSB/BHA shall determine, from among the applicants for enrollment in the waiver included in the urgent category list, who shall be served first based on the needs of those applicants and consistent with these criteria. This determination of the assignment of the slot shall be based on statewide criteria as specified in DBHDS guidance document entitled MR/ID Waiver Slot Assignment Process (rev. 08/20/2010).~~

~~1. The urgent category shall be assigned when the applicant is in need of services because he is determined to meet one or more of the criteria established in subdivision 2 of this subsection and services will be required within 30 days of the date of established need. Only after all applicants in the Commonwealth who meet the urgent criteria have been served shall applicants in the nonurgent category waiting list be permitted to be served.~~

~~2. Assignment to the urgent category may be requested by the applicant, his legally responsible relative, or primary caregiver. The urgent category shall be assigned only when the applicant (who shall have first met all of the waiver's level of care criteria), the applicant's spouse or parent~~

~~(either natural, adoptive, or foster), or the person who has legal decision making authority for an individual who is a minor child would accept the requested service if it were offered. The urgent category list criteria shall be as follows:~~

~~a. Both primary caregivers are 55 years of age or older, or if there is one primary caregiver, that primary caregiver is 55 years of age or older;~~

~~b. The applicant is living with a primary caregiver, who is providing the service voluntarily and without pay, and the primary caregiver indicates that he can no longer care for the applicant with ID;~~

~~e. There is a clear risk for the applicant with the ID of abuse, neglect, or exploitation;~~

~~d. A primary caregiver has a chronic or long term physical or psychiatric condition or conditions that significantly limits the abilities of the primary caregiver or caregivers to care for the applicant with ID;~~

~~e. The applicant with ID is aging out of publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or~~

~~f. The applicant with ID lives with the primary caregiver, and there is a risk to the health or safety of the applicant, primary caregiver, or other person living in the home due to either of the following conditions:~~

~~(1) The applicant's behavior or behaviors present a risk to himself or others that cannot be effectively managed by the primary caregiver even with generic or specialized support arranged or provided by the CSB/BHA; or~~

~~(2) There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided by the CSB/BHA.~~

~~3. The case manager shall notify the individual in writing within 10 business days of receiving DBHDS' notification that he has been placed on the Statewide ID Waiting List-Urgent and of his appeal rights.~~

~~C. Nonurgent waiting list criteria. Applicants in the nonurgent category shall be those who meet the diagnostic and functional criteria for the waiver, including the need for services within 30 days, but who do not meet the urgent criteria. The case manager shall notify the individual in writing within 10 business days of receiving DBHDS' notification that he has been placed on the Statewide ID Waiting List Nonurgent and of his appeal rights.~~

~~12VAC30-120-1090. Appeals.~~

~~A. Providers shall have the right to appeal actions taken by DMAS or its designee. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia), and DMAS~~

regulations at 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

B. Individuals shall have the right to appeal an action, ~~as that term is defined in 42 CFR 431.201, taken by DMAS or its designee.~~ Individuals' appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-370. DMAS shall provide the opportunity for a fair hearing, consistent with 42 CFR Part 431, Subpart E. ~~C.~~ The individual shall be advised in writing of such denial and of his right to appeal consistent with DMAS client appeals regulations 12VAC30-110-70 and 12VAC30-110-80.

Part XV

Day Support Waiver for Individuals with Mental Retardation
Building Independence Waiver

12VAC30-120-1500. Definitions.

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

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560 same as defined in 12VAC30-120-1000.

"Assistive technology" means the same as defined in 12VAC30-120-1000.

"Barrier crime" means the same as defined in 12VAC30-120-1000.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the locality that it serves same as defined in § 37.2-100 of the Code of Virginia.

"Building Independence Waiver" or "BI Waiver" means the waiver set forth in 12VAC30-120-1500 et seq.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the consumer service plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the consumer service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the consumer service plan.

"Case manager" means the individual who performs case management services on behalf of the community services board or behavioral health authority, and who possesses a combination of mental retardation work experience and relevant education that indicates that the individual possesses

the knowledge, skills and abilities as established by the Department of Medical Assistance Services in 12VAC30-50-450.

"Case manager" means the same as defined in 12VAC30-120-1000.

"Center-based crisis support services" means the same as defined in 12VAC30-120-1000.

"Centers for Medicare and Medicaid Services" or "CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs same as defined in 12VAC30-120-1000.

"Community-based crisis support services" means the same as defined in 12VAC30-120-1000.

"Community coaching" means the same as defined in 12VAC30-120-1000.

"Community engagement" means the same as defined in 12VAC30-120-1000.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves same as defined in § 37.2-100 of the Code of Virginia.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care information by the case manager and is used as a basis for the development of the consumer service plan.

"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive Day Support Waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The case manager incorporates the individual service plans in the CSP.

"Crisis support services" means the same as defined in 12VAC30-120-1000.

"DARS" means the Department for Aging and Rehabilitative Services.

"Date of need" means the date of the initial eligibility determination assigned to reflect that the individual is diagnostically and functionally eligible for the waiver and is willing to begin services within 30 days. The date of need is not changed unless the person is subsequently found ineligible or withdraws their request for services.

"Day support services" means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

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"Day Support Waiver for Individuals with Mental Retardation" or "Day Support Waiver" means the program that provides day support, prevocational services, and supported employment to individuals on the Mental Retardation Waiver waiting list who have been assigned a Day Support Waiver slot.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DBHDS staff" means persons employed by the Department of Behavioral Health and Developmental Services.

"Developmental disability" means the same as defined in § 37.2-100 of the Code of Virginia.

"Direct marketing" means the same as defined in 12VAC30-120-1000.

"Direct support professionals" or "DSPs" means the same as defined in 12VAC30-120-1000.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by or contracted with the Department of Medical Assistance Services.

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

"DMHMRSAS staff" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Electronic home-based supports" or "EHBS" means the same as defined in 12VAC30-120-1000.

"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the Day Support Waiver and DMHMRSAS has verified the availability of a Day Support Waiver slot for that individual, and DSS has determined the individual's Medicaid eligibility for home and community based services the same as defined in 12VAC30-120-501.

"Environmental modifications" means the same as defined in 12VAC30-120-1000.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines that prescribe preventive and treatment services for Medicaid-eligible children as defined in 12VAC30-50-130 same as defined in 12VAC30-120-1000.

"Face-to-face visit" means the same as defined in 12VAC30-120-1000.

"Group day services" means the same as defined in 12VAC30-120-1000.

"Group supported employment services" means the same as defined in 12VAC30-120-1000.

"Home and community-based waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to § 1915(e) of the Social Security Act to be offered to persons with mental retardation who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) means the same as defined in 12VAC30-120-1000.

"ICF/IID" means the same as defined in 12VAC30-120-1000.

"Independent living supports" means a service provided to adults, ages 18 years and older, who have developmental disabilities that offers skill building and assistance necessary to secure a self-sustaining, independent living situation in the community or provides the support necessary to maintain those skills. Individuals authorized to receive this service typically live alone or with roommates in their own homes or apartments.

"Individual" means the person receiving the services or evaluations established in these regulations the same as defined in 12VAC30-120-1000.

"Individual service plan" or "ISP" means the service plan related solely to the specific waiver service. Multiple ISPs help to comprise the overall consumer service plan.

"Individual supported employment" means the same as defined in 12VAC30-120-1000.

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

"LDSS" means the local department of social services.

"LMHP" means a licensed mental health professional as defined in 12VAC35-105-20.

"LMHP-resident" means the same as defined in 12VAC30-50-130.

"LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee" means the same as defined in 12VAC30-50-130.

"Medically necessary" means the same as defined in 12VAC30-120-1000.

"Mental retardation" or "MR" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD).

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and DMHMRSAS, and has a current, signed provider

participation agreement with DMAS the same as defined in 12VAC30-120-1000.

"Pend" means the same as defined in 12VAC30-120-1000.

"Person-centered planning" means the same as defined in 12VAC30-120-1000.

"Personal emergency response system" or "PERS" means the same as defined in 12VAC30-120-1000.

"Personal profile" means the same as defined in 12VAC30-120-1000.

"Plan for Supports" means the same as defined in 12VAC30-120-1000.

"Preauthorized" means that an individual service has been approved by DMHMRSAS prior to commencement of the service by the service provider for initiation and reimbursement of services.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs). The services do not include activities that are specifically job task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

"Positive behavior support" means the same as defined in 12VAC30-120-1000.

"Primary caregiver" means the same as defined in 12VAC30-120-1000.

"Qualified developmental disability professionals" or "ODDPs" means the same as defined in 12VAC30-120-1000.

"Risk assessment" means the same as defined in 12VAC30-120-1000.

"Routine supports" means the same as defined in 12VAC30-120-1000.

"Safety supports" means the same as defined in 12VAC30-120-1000.

"Service authorization" means the same as defined in 12VAC30-120-1000.

"Shared living" means the same as defined in 12VAC30-120-1000.

"Skill-building supports" means the same as defined in 12VAC30-120-1000.

"Slot" means an opening or vacancy of waiver services for an individual the same as defined in 12VAC30-120-501.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as

provided for under Title XIX of the Social Security Act means the same as defined in 12VAC30-120-1000.

"Support coordination/case management" means the same as defined in 12 VAC 30-50-455 D.

"Support coordinator/case manager" means the same as defined in 12VAC30-120-1000.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment.

"Supporting documentation" means the same as defined in 12VAC30-120-501.

"Supports" means the same as defined in 12VAC30-120-1000.

"Supports Intensity Scale[®]" or "SIS[®]" means the same as defined in 12VAC30-120-501.

"Transition services" means the same as defined in 12VAC30-120-1000.

"VDSS" means the Virginia Department of Social Services.

12VAC30-120-1510. General coverage and requirements for Day Support Building Independence Waiver services.

A. Waiver service populations. Home and community based waiver services shall be available through a § 1915(e) of the Social Security Act waiver for individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR.

B. A. Covered services. 1. Covered services shall include day support services, prevocational services and supported employment services, assistive technology, center-based crisis support services, community-based crisis support services, community coaching services, community engagement services, crisis support services, electronic home-based supports, environmental modifications, group day services, group and individual supported employment services, independent living supports, personal emergency response systems (PERS), shared living, and transition services to individuals who have been assigned a Building Independence Waiver slot.

2. These services shall be appropriate and necessary to maintain the individual in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in an ICF/MR under the State Plan that would have been provided had the waiver not been granted.

3. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, ICF/MR, or inpatient rehabilitation facility. Individuals with mental retardation who are inpatients of these facilities may receive case management services as described in

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~~12VAC30-50-440. The case manager may recommend waiver services that would promote exiting from the institutional placement; however, these services shall not be provided until the individual has exited the institution.~~

~~4. Under this § 1915(e) waiver, DMAS waives § 1902(a)(10)(B) of the Social Security Act related to comparability.~~

~~C. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.~~

~~D. Slot allocation.~~

~~1. DMHMRSAS will maintain one waiting list, the MR Waiver waiting list described in Part IV (12VAC30-120-211 et seq.) of this chapter, which will be used to assign slots in both the MR Waiver and Day Support Waiver. For Day Support Waiver services, slots will be assigned based on the date of need reported by the case manager when the individual was placed on the MR Waiver waiting list. Individuals interested in receiving Day Support Waiver services who are not currently on the MR Waiver waiting list may apply for services through the local CSB and if found eligible will be placed on the MR Waiver waiting list until a slot is available.~~

~~2. Each CSB will be assigned one Day Support Waiver slot by DMHMRSAS. The remaining slots will be distributed to the CSBs/BHAs based on the percentage of individual cases when compared to the statewide total of cases on the MR Waiver waiting list. All slots shall be allocated based on the individual's date of need and will remain CSB/BHA slots that, when vacated, will be offered to the next individual on the MR Waiver waiting list from that CSB/BHA based upon the date of need.~~

~~3. Individuals may remain on the MR Waiver waiting list while receiving Day Support Waiver services.~~

~~E. Reevaluation of service need and utilization review. Case managers shall complete reviews and updates of the CSP and level of care as specified in 12VAC30-120-1520 D.~~

B. Core competency requirements for direct support professionals (DSPs) and their supervisors in programs licensed by DBHDS shall be the same as those set forth in 12VAC30-120-515 A.

C. Core competency requirements for support coordinators/case managers. (Reserved.)

D. Core competency requirements for QDDPs. (Reserved.)

E. Advanced core competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs as identified by assignment to Level 5, 6, or 7 shall be the same as those set forth in 12VAC30-120-515 D.

F. Provider enrollment requirements shall be the same as those set forth in 12VAC30-120-514.

G. Providers shall meet the documentation requirements as specified in 12VAC30-120-514 Q.

H. Reevaluation of service need requirements shall be the same as those specified in 12VAC30-120-515 F.

I. Utilization review requirements shall be the same as those set forth in 12VAC30-120-515 G.

12VAC30-120-1520. Individual eligibility requirements. (Repealed.)

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

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

~~2. Virginia shall reduce its payment for home and community based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and § 1915(e)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community based waiver services by the amount that remains after the deductions listed below:~~

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

~~(1) The basic maintenance needs for an individual, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week,~~

earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

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

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

(1) The basic maintenance needs for an individual, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

necessary medical or remedial care recognized under state law but not covered under the State Plan for Medical Assistance.

B. Assessment and enrollment.

1. To ensure that Virginia's home and community based waiver programs serve only individuals who would otherwise be placed in an ICF/MR, home and community-based waiver services shall be considered only for individuals with a diagnosis of mental retardation. For the case manager to make a recommendation for waiver services, Day Support Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR ICF/IID, or promote exiting from either an ICF/MR placement or other institutional placement.

2. The case manager shall recommend the individual for home and community based waiver services after completion of a comprehensive assessment of the individual's needs and available supports. This assessment process for home and community based waiver services by the case manager is mandatory before Medicaid will assume payment responsibility of home and community-based waiver services. The comprehensive assessment includes:

a. Relevant medical information based on a medical examination completed no earlier than 12 months prior to beginning waiver services;

b. The case manager's functional assessment that demonstrates a need for each specific service. The functional assessment must be a DMHMRSAS approved assessment completed no earlier than 12 months prior to beginning waiver services;

c. The level of care required by applying the existing DMAS ICF/MR criteria, Part VI (12VAC30-130-430 et seq.) of 12VAC30-130, completed no more than six months prior to the start of waiver services. The case manager determines whether the individual meets the ICF/MR criteria with input from the individual, family/caregivers, and service and support providers involved in the individual's support in the community; and

d. A psychological evaluation that reflects the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

3. The case manager shall provide the individual and family/caregiver with the choice of Day Support Waiver services or ICF/MR placement.

4. The case manager shall send the appropriate forms to DMHMRSAS to enroll the individual in the Day Support Waiver or, if no slot is available, to place the individual on the Mental Retardation Waiver waiting list. DMHMRSAS shall only enroll the individual if a slot is available.

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~~C. Waiver approval process; authorizing and accessing services.~~

~~1. Once the case manager has determined an individual meets the criteria for Day Support Waiver services, has determined that a slot is available, and that the individual has chosen this service, the case manager shall submit updated enrollment information to DMHMRSAS to confirm level of care eligibility and the availability of a slot.~~

~~2. Once the individual has been enrolled by DMHMRSAS, the case manager will submit a DMAS 122 along with a written confirmation from DMHMRSAS of level of care eligibility, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities.~~

~~3. After the case manager has received written notification of Medicaid eligibility by DSS and written enrollment confirmation from DMHMRSAS, the case manager shall inform the individual or family/caregiver so that the CSP can be developed. The individual or individual's family/caregiver will meet with the case manager within 30 calendar days following the receipt of written notification of DMHMRSAS enrollment to discuss the individual's needs and existing supports, and to develop a CSP that will establish and document the needed services. The case manager provides the individual and family/caregiver with choice of needed services available under the Day Support Waiver, alternative settings and providers. A CSP shall be developed with the individual based on the assessment of needs as reflected in the level of care and functional assessment instruments and the individual's, family/caregiver's preferences. The CSP development process identifies the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered. Only services on the CSP authorized by DMHMRSAS according to DMAS policies will be reimbursed by DMAS.~~

~~4. The individual or case manager shall contact the service providers chosen by the individual/family caregiver, as appropriate, so that services can be initiated within 60 days of receipt of enrollment confirmation from DMHMRSAS. The service providers in conjunction with the individual, individual's family/caregiver and case manager will develop Individual Service Plans (ISP) for each service. A copy of each ISP will be submitted to the case manager. The case manager will review and ensure that each ISP meets the established service criteria for the identified needs. The ISP from each waiver service provider shall be incorporated into the CSP.~~

~~5. If waiver services are not initiated within 60 days from receipt of enrollment confirmation, the case manager must submit written information to DMHMRSAS requesting more time to initiate services. A copy of the request must~~

~~be provided to the individual or the individual's family/caregiver. DMHMRSAS has the authority to approve the request in 30 day extensions, up to a maximum of four consecutive extensions, or to deny the request to retain the waiver slot for that individual. DMHMRSAS shall provide a written response to the case manager indicating denial or approval of the extension. DMHMRSAS shall submit this response within 10 business days of the receipt of the request for extension.~~

~~6. The case manager must submit the results of the comprehensive assessment and a recommendation to the DMHMRSAS staff for final determination of ICF/MR level of care and authorization for community based services. DMHMRSAS shall, within 10 business days of receiving all supporting documentation, review and approve, pend for more information, or deny the individual service requests. DMHMRSAS will communicate in writing to the case manager whether the recommended services have been approved and the amounts and type of services authorized or if any have been denied. Medicaid will not pay for any home and community based waiver services delivered prior to the authorization date approved by DMHMRSAS if preauthorization is required.~~

~~7. Day Support Waiver services may be recommended by the case manager only if:~~

- ~~a. The individual is Medicaid eligible as determined by the local office of the Department of Social Services;~~
- ~~b. The individual has a diagnosis of mental retardation as defined by the American Association on Mental Retardation and would in the absence of waiver services, require the level of care provided in an ICF/MR facility, the cost of which would be reimbursed under the Plan; and~~
- ~~c. The contents of the individual service plans are consistent with the Medicaid definition of each service.~~

~~8. All CSPs are subject to approval by DMAS. DMAS shall be the single state agency authority responsible for the supervision of the administration of the Day Support Waiver and is responsible for conducting utilization review activities. DMHMRSAS shall conduct preauthorization of waiver services.~~

~~D. Reevaluation of service need.~~

~~1. The consumer service plan.~~

~~a. The case manager shall update the CSP annually based on relevant, current assessment data; in updating the CSP, the case manager shall work with the individual, the individual's family/caregiver, other service providers, consultants, and other interested parties.~~

~~b. The case manager shall be responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the CSP as indicated by the changing needs of the individual. At a minimum, the case manager must review the CSP every three months to~~

determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

e. Any modification to the amount or type of services in the CSP must be approved by the individual or family/caregiver and authorized by DMHMRSAS.

2. Review of level of care.

a. The case manager shall complete a reassessment annually, in coordination with the individual, family/caregiver, and service providers. The reassessment shall include an update of the level of care and functional assessment instrument and any other appropriate assessment data. If warranted, the case manager shall coordinate a medical examination and a psychological evaluation for the individual. The CSP shall be revised as appropriate.

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

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

3. The case manager will monitor the service providers' ISPs to ensure that all providers are working toward the identified goals of the affected individuals.

4. Case managers will be required to conduct monthly visits at the assisted living facility or approved adult foster care placement for all Day Support Waiver individuals residing in DSS licensed or DSS regulated placements.

5. The case manager must request an updated DMAS 122 form from DSS annually and forward a copy of the updated DMAS 122 form to all service providers when obtained.

12VAC30-120-1530. General requirements for home and community-based participating providers. (Repealed.)

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

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

2. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid program at the time the service or services were performed;

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

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

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

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

7. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS payment methodology from the individual's authorization date for the waiver services;

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

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

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

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

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

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in

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any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

12. Hold confidential and use for authorized purposes only all medical assistance information regarding individuals served, pursuant to 42 CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable state or federal law;

13. Notify DMAS when ownership of the provider changes at least 15 calendar days before the date of change;

14. Properly report cases of suspected abuse or neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community based waiver service individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DSS adult or child protective services worker and to DMHMRSAS Offices of Licensing and Human Rights as applicable; and

15. Adhere to the provider participation agreement and the DMAS provider manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the DMAS provider manual.

B. Documentation requirements.

1. The case manager must maintain the following documentation for utilization review by DMAS for a period of not less than six years from each individual's last date of service:

- a. The comprehensive assessment and all CSPs completed for the individual;
- b. All ISPs from every provider rendering waiver services to the individual;
- c. All supporting documentation related to any change in the CSP;
- d. All related communication with the individual, family/caregiver, consultants, providers, DMHMRSAS, DMAS, DSS, DRS or other related parties;
- e. An ongoing log that documents all contacts made by the case manager related to the individual and family/caregiver; and
- f. A copy of the current DMAS 122 form.

2. The service providers must maintain, for a period of not less than six years from the individual's last date of service, documentation necessary to support services billed. DMAS staff shall conduct utilization review of individual specific documentation. This documentation shall contain, up to and including the last date of service, all of the following:

- a. All assessments and reassessments;
- b. All ISPs developed for that individual and the written reviews;
- c. An attendance log that documents the date services were rendered, as well as documentation of the amount and type of services rendered;
- d. Appropriate data, contact notes, or progress notes reflecting an individual's status and, as appropriate, progress or lack of progress toward the goals on the ISP;
- e. Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community; and
- f. A copy of the current DMAS 122 form.

C. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides Day Support Waiver services for the individual.

12VAC30-120-1540. Participation standards for home and community-based waiver services participating providers.

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

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

1. Licensure and certification requirements pursuant to 42 CFR 441.302;
2. Disclosure of ownership pursuant to 42 CFR 455.104 and 455.105; and
3. The ability to document and maintain individual case records in accordance with state and federal requirements.

C. The case manager must inform the individual of all available waiver service providers. The individual shall have the option of selecting the provider of his choice from among those providers meeting the individual's needs.

D. DMAS shall be responsible for reviewing continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for participation agreement renewal with DMAS to provide home and community based waiver services.

E. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS may terminate at will a provider's participation agreement on 30 days' written notice as specified in the DMAS participation agreement. DMAS may also immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the program. Such action precludes further payment by DMAS for services provided to individuals subsequent to the date of termination.

~~F. A provider shall have the right to appeal action taken by DMAS pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.~~

~~G. Section 32.1-325 D-2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, D.C., must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. In addition, termination of a provider participation agreement will occur as may be required for federal financial participation.~~

~~H. Case manager's responsibility for the Individual Information Form (DMAS 122). It shall be the responsibility of the case management provider to notify DMHMRSAS and DSS, in writing, within five business days of being informed of any of the circumstances described in this subsection:~~

- ~~1. Home and community based waiver services are initiated.~~
- ~~2. A recipient dies.~~
- ~~3. A recipient is discharged from Day Support Waiver services.~~
- ~~4. Any other circumstances (including hospitalization) that cause home and community based waiver services to cease or be interrupted for more than 30 days.~~
- ~~5. A selection by the individual or family/caregiver of a different community services board/behavioral health authority providing case management services.~~

~~I. Changes or termination of services. DMHMRSAS shall authorize changes to an individual's CSP based on the recommendations of the case manager. Providers of waiver services are responsible for modifying their Individual Service Plans (ISPs) with the involvement of the individual or family/caregiver, and submitting them to the case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered. The case manager will review the need for a change and may recommend a change to the ISP to the DMHMRSAS staff. DMHMRSAS will review and approve, deny, or pend for additional information the requested change to the individual's ISP, and communicate this to the case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency, within three business days of receipt of the request for change.~~

~~The individual or family/caregiver will be notified, in writing, of the right to appeal the decision or decisions to reduce, terminate, suspend or deny services pursuant to DMAS client appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC 30-110. The case manager must submit this notification to the individual in writing within 10 business days of the decision. All CSPs are subject to approval by the Medicaid agency.~~

~~1. In a nonemergency situation, the participating provider shall give the individual or family/caregiver and case manager 10 business days prior written notice of the provider's intent to discontinue services. The notification letter shall provide the reasons why and the effective date the provider is discontinuing services. The effective date that services will be discontinued shall be at least 10 business days from the date of the notification letter.~~

~~2. In an emergency situation, when the health and safety of the individual, other individuals in that setting, or provider personnel is endangered, the case manager and DMHMRSAS must be notified prior to the provider discontinuing services. The 10 business day written notification period shall not be required. If appropriate, the local DSS adult protective services or child protective services and DMHMRSAS Offices of Licensing and Human Rights must be notified immediately.~~

~~3. In the case of termination of home and community-based waiver services by the CSB/BHA, DMHMRSAS or DMAS staff, individuals shall be notified of their appeal rights by the case manager pursuant to Part I (12VAC30-110-10 et seq.) of 12VAC30-110. The case manager shall have the responsibility to identify those individuals who no longer meet the level of care criteria or for whom home and community based waiver services are no longer an appropriate alternative.~~

Participation standards for home and community-based waiver services participating providers are set forth in 12VAC30-120-500 et seq.

12VAC30-120-1550. Services: day support services, prevocational services and supported employment services. (Repealed.)

A. Service descriptions:

~~1. Day support means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.~~

~~2. Prevocational services means services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs). The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.~~

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3. Supported employment services are provided in work settings where persons without disabilities are employed. It is especially designed for individuals with developmental disabilities, including individuals with mental retardation, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential.

a. Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disability need ongoing support to perform in a work setting.

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

B. Criteria.

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

2. For prevocational services, the individual must demonstrate the need for support in skills that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

3. For supported employment, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports, and that because of his disability, he needs ongoing support to perform in a work setting.

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

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

C. Service types. The amount and type of day support and prevocational services included in the individual's service plan is determined according to the services required for that individual. There are two types of services: center-based, which is provided primarily at one location/building, and noncenter based, which is provided primarily in community settings. Both types of services may be provided at either intensive or regular levels. For supported employment, the

ISP must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the individual's ISP.

D. Intensive level criteria. For day support and prevocational services to be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) require physical assistance to meet the basic personal care needs (toileting, feeding, etc); (ii) have extensive disability related difficulties and require additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

E. Service units. Day support, prevocational and group models of supported employment (enclaves, work crews, bench work and entrepreneurial model of supported employment) are billed in accordance with the DMAS fee schedule.

F. Service limitations:

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

2. The supporting documentation must provide an estimate of the amount of services required by the individual. Service providers are reimbursed only for the amount and type of services included in the individual's approved ISP based on the setting, intensity, and duration of the service to be delivered.

3. Day support, prevocational and group models of supported employment services shall be limited to a total of 780 units per CSP year, or its equivalent under the DMAS fee schedule. If an individual receives a combination of day support, prevocational and/or supported employment services, the combined total shall not exceed 780 units per CSP year, or its equivalent under the DMAS fee schedule.

4. The individual job placement model of supported employment is limited to 40 hours per week.

5. For day support services:

a. Day support cannot be regularly or temporarily provided in an individual's home or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from DMHMRSAS.

b. Noncenter based day support services must be separate and distinguishable from other services.

6. For the individual job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the

provider, not the amount of time the individual is in the supported employment situation.

G. Provider requirements. In addition to meeting the general conditions and requirements for home and community based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, service providers must meet the following requirements:

1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services. The provider of prevocational services must be a vendor of extended employment services, long term employment services, or supported employment services for DRS, or be licensed by DMHMRSAS as a provider of day support services.

2. Supported employment shall be provided only by agencies that are DRS vendors of supported employment services;

3. In addition to any licensing requirements, persons providing day support or prevocational services are required to participate in training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations prior to providing direct services. All providers of services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

4. Required documentation in the individual's record. The provider agency must maintain records of each individual receiving services. At a minimum these records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the service environment and community settings.

b. An ISP that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports and training needs;

(2) The individual's goals and, a sequence of measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives as appropriate;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

e. Documentation confirming the individual's attendance and amount of time in services, type of services rendered, and specific information regarding the individual's

response to various settings and supports as agreed to in the ISP objectives. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided.

d. Documentation indicating whether day support or prevocational services were center based or noncenter-based.

e. In instances where staff are required to ride with the individual to and from the service in order to provide needed supports as specified in the ISP, the staff time can be billed as day support, prevocational or supported employment services, provided that the billing for this time does not exceed 25% of the total time spent in the day support, prevocational or supported employment activity for that day. Documentation must be maintained to verify that billing for staff coverage during transportation does not exceed 25% of the total time spent in the service for that day.

f. If intensive day support or prevocational services are requested, there shall be documentation indicating the specific supports and the reasons they are needed. For ongoing intensive services, there must be clear documentation of the ongoing needs and associated staff supports.

g. The ISP goals, objectives, and activities must be reviewed by the provider quarterly and annually, or more often as needed and the results of the review submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual or family/caregiver.

h. Copy of the most recently completed DMAS 122 form. The provider must clearly document efforts to obtain the completed DMAS 122 form from the case manager.

i. For prevocational or supported employment services, documentation regarding whether prevocational or supported employment services are available through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for services through the IDEA, documentation is required only for lack of DRS funding. When services are provided through these sources, the ISP shall not authorize such services as a waiver expenditure.

j. Prevocational services can only be provided when the individual's compensation is less than 50% of the minimum wage.

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12VAC30-120-1552. Covered services; services descriptions.

Service descriptions.

1. Assistive technology (AT) service description. The service definition is the same as that set forth in 12VAC30-120-1021 A.
2. Benefits planning. (Reserved.)
3. Center-based crisis support. The service description is the same as that set forth in 12VAC30-120-1024 A 2.
4. Community-based crisis support services. The service description is the same as that set forth in 12VAC30-120-1024 A 3.
5. Community coaching. The service description shall be the same as that set forth in 12VAC30-120-1022 B 1.
6. Community engagement. The service description shall be the same as that set forth in 12VAC30-120-1022 A 1.
7. Community guide. (Reserved.)
8. Crisis support services. The service description shall be the same as that set forth in 12VAC30-120-1024 A 1.
9. Electronic home-based supports (EHBS). The service description shall be the same as that set forth in 12VAC30-120-1025 A 1.
10. Environmental modifications (EM). The service description shall be the same as that set forth in 12VAC30-120-1025 B 1.
11. Group day services. The service description shall be the same as that set forth in subdivision 1 of 12VAC30-120-1026.
12. Group supported employment. The service description shall be the same as that set forth in 12VAC30-120-1035 A.
13. Independent living supports means a service provided to adults 18 years of age and older that offers skill building and assistance necessary to secure a self-sustaining, independent living situation in the community and provide the support necessary to maintain those skills. Individuals receiving this service typically live alone or with roommates in their own homes or apartments. The supports may be provided in the individual's residence or in other community settings. Independent living supports is a tiered service for reimbursement purposes. Providers shall only be reimbursed for the individual's assigned level and tier.
14. Individual supported employment. The service description shall be the same as set forth in 12VAC30-120-1035 A.
15. Nonmedical transportation. (Reserved.)
16. Personal emergency response systems (PERS). The service description shall be the same as that set forth in subdivision 1 of 12VAC30-120-1030.
17. Shared living. The service description shall be the same as that set forth in subdivision 1 of 12VAC30-120-1034 A 1.
18. Transition services. The service description shall be the same as that set forth in 12VAC30-120-1038.

12VAC30-120-1554. Criteria that must be met to receive covered services.

- A. Assistive technology criteria shall be the same as those set forth in 12VAC30-120-1021 A 1.
- B. Benefits planning. (Reserved.)
- C. Center-based crisis supports. Criteria shall be the same as those set forth in 12VAC30-120-1024 B 2.
- D. Community-based crisis supports. Criteria shall be the same as those set forth in 12VAC30-120-1024 B 3.
- E. Community coaching. The criteria shall be the same as those set forth in 12VAC30-120-1022 B 2.
- F. Community engagement. The criteria shall be the same as those set forth in 12VAC30-120-1022 A 2.
- G. Community guide activities. (Reserved.)
- H. Crisis support services. The criteria shall be the same as those set forth in 12VAC30-120-1024 B 1.
- I. Electronic home-based supports (EHBS). The criteria shall be the same as those set forth in 12VAC30-120-1025 A 2.
- J. Environmental modifications. The criteria shall be the same as those set forth in 12VAC30-120-1025 B 2.
- K. Group day services. The criteria shall be the same as those set forth in subdivision 2 of 12VAC30-120-1026.
- L. Group supported employment. The criteria shall be the same as those set forth in 12VAC30-120-1035 B.
- M. The need for independent living supports shall be clearly indicated in the ISP. This service provides skill-building to (i) promote the individual's community participation and inclusion in meaningful activities; (ii) increase socialization skills and maintain relationships; (iii) improve and maintain the individual's health, safety and fitness, as necessary; (iv) promote the individual's decision-making and self-determination skills; and (v) improve and support as needed the individual's skills with ADLs and IADLs. These services shall not be provided in a licensed residential setting.
- N. Individual supported employment. The criteria shall be the same as those set forth in 12VAC30-120-1035 B.
- O. Nonmedical transportation. (Reserved.)
- P. Personal emergency response system (PERS). The criteria shall be the same as those set forth in subdivision 2 of 12VAC30-120-1030.
- Q. Shared living. The criteria shall be the same as those set forth in subdivision 2 of 12VAC30-120-1034.
- R. Transition services. The criteria shall be the same as those set forth in 12VAC30-120-1038, 12VAC30-120-2000, and 12VAC30-120-2010.

12VAC30-120-1556. Allowable activities.

Allowable activities.

1. Benefits planning activities. (Reserved.)

2. Community coaching. Allowable activities shall be the same as those set forth in 12VAC30-120-1022 B 3.

3. Community engagement. Allowable activities shall be the same as those set forth in 12VAC30-120-1022 A 3.

4. Community guide. (Reserved.)

5. Group day services. The allowable activities shall be the same as those set forth in subdivision 3 of 12VAC30-120-1026.

6. Group supported employment. The allowable activities shall be the same as those set forth in 12VAC30-120-1035 C.

7. Independent living supports allowable activities include skill building and supports to promote (i) the individual's community participation and inclusion; (ii) socialization skills to develop and maintain relationships; (iii) the individual's health, safety and fitness; (iv) the individual's decision-making and self-determination skills; (v) the individual's engagement in meaningful community activities; and (vi) supports related to ADLs and IADLs.

8. Individual supported employment. The allowable activities shall be the same as those set forth in 12VAC30-120-1035 C.

9. Nonmedical transportation. (Reserved.)

10. Shared living. The allowable activities shall be the same as those set forth in subdivision 3 of 12VAC30-120-1034.

11. Transition services. The allowable activities shall be the same as those set out in 12VAC30-120-1038, 12VAC30-120-2000, and 12VAC30-120-2010.

12. Crisis support services. The allowable activities shall be the same as those set forth in 12VAC30-120-1024 C 1 and C 2.

13. Center-based crisis support services. The allowable activities shall be the same as those set forth in 12VAC30-120-1024 C 3.

14. Community-based crisis support services. The allowable activities shall be the same as those set forth in 12VAC30-120-1024 C 4.

12VAC30-120-1558. Units and limits on covered services.

Limits on covered services.

1. AT service units and services shall be the same as those set forth in 12VAC30-120-1021 A 2 and A 3.

2. Benefits planning. (Reserved.)

3. Center-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024 D 2.

4. Community-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024 D 3.

5. Community coaching. Service units and limits shall be the same as those set forth in 12VAC30-120-1022 B 4.

6. Community engagement. Service units and limits shall be the same as those set forth in 12VAC30-120-1022 A 4.

7. Community guide. (Reserved.)

8. Crisis support services. Service units and limits shall be the same as those set forth in 12VAC30-120-1024 D 1.

9. Environmental modifications. Service units and limits shall be the same as those set forth in 12VAC30-120-1025 B 3.

10. Group day services. The service units and limits shall be the same as those set forth in subdivision 4 of 12VAC30-120-1026.

11. Group supported employment. The service units and limits shall be the same as those set forth in 12VAC30-120-1035 D.

12. The independent living supports unit of service delivery shall be a month or, when beginning or ceasing the service, may be a partial month. Individuals who have been approved for this service shall receive no more than 21 hours of independent living supports per week (Sunday through Saturday) in the individual's home or in community settings. This service shall not be provided in a licensed residential setting.

13. Individual supported employment. The service units and limits shall be the same as those set forth in 12VAC30-120-1035 D.

14. Nonmedical transportation. (Reserved.)

15. Personal emergency response systems. The service units and limits shall be the same as those set forth in subdivision 3 of 12VAC30-120-1030.

16. Shared living. Service units and limits shall be the same as those set forth in subdivision 4 of 12VAC30-120-1034.

17. Transition services. Service units and limits shall be the same as those set forth in 12VAC30-120-1038, 12VAC30-120-2000, and 12VAC30-120-2010.

12VAC30-120-1560. Provider requirements.

In addition to meeting the general conditions and requirements for home and community-based waiver participating providers as specified in 12VAC30-120-501 et seq., service providers shall meet the following requirements:

1. Assistive technology providers shall meet all of the requirements set forth in 12VAC30-120-1021 A 4 and 12VAC30-120-1061 A and B.

2. Benefits planning. (Reserved.)

3. Center-based crisis support providers shall meet all of the requirements set forth in 12VAC30-120-1024 E and 12VAC30-120-1063 B.

4. Community-based crisis support providers shall meet all of the requirements set forth in 12VAC30-120-1024 E and 12VAC 30-120-1063 C.

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5. Community coaching providers shall meet all of the requirements set forth in 12VAC30-120-1022 B 5 and 12VAC30-120-1065 B.

6. Community engagement providers shall meet all of the requirements set forth in 12VAC30-120-1022 A 5 and 12VAC30-120-1065 A.

7. Community guide services. (Reserved.)

8. Crisis support services providers shall meet all of the requirements set forth in 12VAC30-120-1024 E and 12VAC30-120-1063 A.

9. Electronic home based services providers shall meet all of the requirements set forth in 12VAC30-120-1025 A 4 and 12VAC30-120-1061.

10. Environmental modification (EM) providers shall meet all of the requirements set forth in 12VAC30-120-1025 B 4 and 12VAC30-120-1061.

11. Group day services providers shall meet all of the requirements set forth in subdivision 5 of 12VAC30-120-1026.

12. Group supported employment providers shall meet all of the requirements set forth in 12VAC30-120-1035 E and 12VAC30-120-1066 A and B.

13. Independent living supports shall be provided by agencies licensed by DBHDS as providers of supportive in-home services. These providers shall have a signed participation agreement with DMAS. The provider designated on the agreement shall directly provide independent living support services and directly bill DMAS for reimbursement. Providers shall ensure that persons rendering in-home support services have received training in the characteristics of intellectual and developmental disabilities and the appropriate interventions, training strategies, and support methods for individuals with functional limitations prior to providing waiver services. All providers of in-home support services shall pass (with a minimum score of 80%) an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS defined procedures. (See www.dbhds.virginia.gov for further information.)

14. Individual supported employment providers shall meet all of the requirements set forth in 12VAC30-120-1035 E and 12VAC30-120-1066 A and B.

15. Nonmedical transportation providers. (Reserved.)

16. Personal emergency response systems provider requirements. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-501 et seq., subdivision 4 of 12VAC30-120-1030, and 12VAC30-120-1061 A and E, providers shall also meet the following requirements:

a. A PERS provider shall be either a (i) licensed home health or personal care agency, (ii) a durable medical equipment provider, (iii) a hospital, 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.

b. The PERS provider shall have a current, signed provider participation agreement with DMAS. This agreement shall be renewed promptly when requested by DMAS. The provider named on this participation agreement shall directly render these PERS services and shall submit his claims to DMAS for reimbursement.

c. The PERS provider shall provide an emergency response center staff 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, as appropriate, days per year; of determining whether an emergency exists; and of notifying an emergency response organization or an emergency responder that the individual needs emergency help.

d. A PERS provider shall comply with all applicable federal and state laws and regulations, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed.

e. 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 or family/caregiver's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit while the original equipment is being repaired.

f. The PERS provider shall properly install all PERS equipment into the functioning telephone line or cellular system of an individual receiving PERS and shall furnish all supplies necessary to ensure that the system is installed and working properly.

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

h. The PERS provider shall install, test, and demonstrate to the individual and family/caregiver, as appropriate, the PERS system before submitting the claim for reimbursement to DMAS.

i. A PERS provider shall maintain all installed PERS equipment in proper working order.

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

- (1) Delivery date and installation date of the PERS;
- (2) The signature of the individual or his family/caregiver, as appropriate, verifying receipt of PERS device;
- (3) Verification by a test that the PERS device is operational, monthly or more frequently as needed;
- (4) Updated and current individual responder and contact information, as provided by the individual or the individual's care provider, or support coordinator/case manager; and
- (5) A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, support coordinator/case manager, or responder.

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

l. Standards for PERS equipment. All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device 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.

m. A PERS provider shall instruct the individual, his family/caregiver, as appropriate, and responders in the use of the PERS service.

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

o. Monitoring agencies shall be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meet the requirements of this section. The monitoring agency shall be capable of simultaneously

responding to multiple signals for help from multiple individuals' PERS equipment. The monitoring agency's equipment shall include the following:

- (1) A primary receiver and a back-up receiver, which shall be independent and interchangeable;
- (2) A back-up information retrieval system;
- (3) A clock printer, which shall print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- (4) A back-up power supply;
- (5) A separate telephone service;
- (6) A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and
- (7) A telephone line monitor, which shall give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

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

q. The PERS provider shall document and furnish within 30 calendar days of the action taken a written report to the support coordinator/case manager for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or activations made in error.

r. The PERS provider shall be prohibited from performing any type of direct marketing activities.

17. Shared living administrative providers shall have a signed provider participation agreement with DMAS and shall meet all of the requirements set forth in subdivision 5 of 12VAC30-120-1034 and 12VAC30-120-1069. The provider designated in this agreement shall directly coordinate the services and directly bill DMAS for reimbursement. The administrative provider shall ensure that there is a back-up plan in place in the event that the live-in companion is unable or unavailable to provide supports. The administrative provider shall maintain documentation of the actual rent or mortgage and utilities costs and submit it with the service authorization request. The approvable amount for rent and utilities costs shall be the lesser of the live-in companion's half of the rent cost incurred by the individual receiving waiver services and utilities costs or the maximum allowable amount for the region of the state in which the individual and live-in companion reside. The maximum reimbursable room and board shall be based on the range of fair market rent in the state, using one rate for Northern Virginia and another for the rest of the state as established by DMAS. The

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administrative providers shall submit monthly claims for reimbursement. A DBHDS provider possessing a DBHDS triennial group home and community residential services license, shall manage the administrative aspects of this service, including roommate matching as needed, background checks, training as needed, periodic onsite monitoring, and disbursing funds to the individual. This provider agency shall be reimbursed a flat fee payment for the completion of these duties. DMAS shall audit such provider's records for compliance with these requirements.

18. Transition services. These provider requirements shall be the same as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

12VAC30-120-1580. Payments for services.

A. All assistive technology, crisis support services, center-based crisis support services, community-based crisis support services, environmental modification, electronic home based services, community engagement, community coaching, group day services, independent living supports, individual supported employment, group supported employment, PERS, shared living, and transition services provided in this waiver shall be reimbursed consistent with the agency's service limits and payment amounts as set out in the fee schedule, available at www.dmas.virginia.gov.

B. Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same services. Reimbursement rates for group supported employment shall be as set by DMAS.

C. All AT, EM, and EHBS covered procedure codes provided in the BI Waiver shall be reimbursed as a service limit of one. The maximum Medicaid funded expenditure per individual for all AT, EM, and EHBS covered procedure codes shall be \$5,000 for AT, EM or EHBS each per calendar year. No additional mark-ups, such as in the durable medical equipment rules, shall be permitted.

D. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, the Virginians with Disabilities Act, or any other applicable statute.

2. Payment for services under the Individual Support Plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

3. Payment for services under the Individual Support Plans shall not be made for services that are duplicative of each other. Expenditures made for services determined in post payment review audits to be duplicative shall be recovered by DMAS.

4. Payments for services shall only be provided as set out in the individuals' Individual Support Plans.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC30-120)

Virginia Uniform Assessment Instrument (UAI) (1994)

~~Consent to Exchange Information, DMAS-20 (rev. 4/03)~~

[Provider Aide Record \(Personal/Respite Care\), DMAS-90 \(rev. 6/12\)](#)

[LPN Skilled Respite Record, DMAS-90A \(eff. 7/05\)](#)

~~Personal Assistant/Companion Timesheet, DMAS-91 (rev. 8/03)~~

[Questionnaire to Assess an Applicant's Ability to Independently Manage Consumer-Directed Services, DMAS-95 Addendum \(rev. 8/05\)](#)

[Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 \(rev. 8/12\)](#)

[Individual Choice - Institutional Care or Waiver Services Form, DMAS-97 \(rev. 8/12\)](#)

[Agency or Consumer Direction Provider Plan of Care, DMAS-97A/B \(rev. 3/10\)](#)

[Community-Based Care Recipient Assessment Report, DMAS-99 \(rev. 9/09\)](#)

[Community-Based Care Level of Care Review Instrument, DMAS-99LOC \(undated\)](#)

[Medicaid LTC Communication Form, DMAS-225 \(rev.10/11\)](#)

[Technology Assisted Waiver Provider RN Initial Home Assessment, DMAS-116 \(11/10\)](#)

[Technology Assisted Waiver/EPSTD Nursing Services Provider Skills Checklist for Individuals Caring for Tracheostomized and/or Ventilator Assisted Children and Adults, DMAS-259](#)

[Home Health Certification and Plan of Care, CMS-485 \(rev. 2/94\)](#)

~~IFDDS Waiver Level of Care Eligibility Form (eff. 5/07)~~

[Request for Screening for Individual and Family Developmental Disabilities Support Waiver \(DD Waiver\), DMAS 305 \(rev. 3/09\)](#)

[DD Medicaid Waiver - Level of Functioning Survey Summary Sheet, DMAS-458 \(undated\)](#)

[Technology Assisted Waiver Adult Aide Plan of Care, DMAS 97 T \(rev. 6/08\)](#)

[Technology Assisted Waiver Supervisory Monthly Summary, DMAS 103 \(rev. 4/08\)](#)

[Technology Assisted Waiver Adult Referral, DMAS 108 \(rev. 3/10\)](#)

[Technology Assisted Waiver Pediatric Referral, DMAS 109 \(rev. 3/10\)](#)

[Skill Competencies for Professionals and Direct Support Staff in Virginia Supporting Adolescents and Adults with Autism, DMAS-P201 \(eff. 6/2014\)](#)

[Virginia Individual Developmental Disabilities Eligibility Survey - Infants' Version, DMAS-P235 \(eff. 3/2016\)](#)

[Virginia Individual Developmental Disabilities Eligibility Survey - Children's Version, DMAS-P236 \(4/2016\)](#)

[Virginia Individual Developmental Disabilities Eligibility Survey - Adult Version, DMAS-P237 \(eff. 3/2016\)](#)

[Behavioral Support Competencies for Direct Support Providers and Professionals in Virginia Supporting Individuals with Developmental Disabilities, DMAS-P240a \(eff. 8/2015\)](#)

[Virginia's Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities - DSP and Supervisor's Competencies Checklist, DMAS-P241a \(eff. 6/2016\)](#)

[Direct Support Professional Assurance \(for DBHDS-Licensed Providers\), DMAS-P242a \(eff. 6/2016\)](#)

[Direct Support Professional Assurance \(for Non-DBHDS-Licensed Providers\), DMAS-P243a \(eff. 6/2016\)](#)

[Virginia's Health Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities - Health Competencies Checklist, DMAS-P244a \(eff. 6/2016\)](#)

[Supervisor Assurance \(for DBHDS-Licensed Providers\), DMAS-P245a \(eff. 7/2016\)](#)

[Supervisor Assurance \(for Non-DBHDS-Licensed Providers\), DMAS-P246a \(eff. 7/2016\)](#)

VA.R. Doc. No. R17-4614; Filed August 24, 2016, 11:15 a.m.



TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

COMMON INTEREST COMMUNITY BOARD

Proposed Regulation

Title of Regulation: 18VAC48-70. Common Interest Community Ombudsman Regulations (amending 18VAC48-70-40).

Statutory Authority: § 55-530 of the Code of Virginia.

Public Hearing Information:

September 26, 2016 - 10 a.m. - Department of Professional and Occupational Regulation, Perimeter

Center, 9960 Mayland Drive, Suite 200, Training Room 2, Richmond, Virginia 23233

Public Comment Deadline: November 18, 2016.

Agency Contact: Trisha Henshaw, Executive Director, Common Interest Community Board, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8510, FAX (866) 490-2723, or email cic@dpor.virginia.gov.

Basis: Section 55-530 I of the Code of Virginia authorizes the Common Interest Community Board to prescribe regulations to accomplish the purpose of Chapter 29 (§ 55-528 et seq.) of Title 55 of the Code of Virginia (Common Interest Community Management Information Fund).

In addition, § 55-530 E of the Code of Virginia requires the board to establish by regulation a requirement that each association establish reasonable procedures for the resolution of written complaints from the members of the association and other citizens.

Section 54.1-201 E of the Code of Virginia authorizes regulatory boards to promulgate regulations in accordance with the Administrative Process Act necessary to assure continued competence, to prevent deceptive or misleading practices by practitioners, and to effectively administer the regulatory system administered by the regulatory board.

Purpose: 18VAC48-70-40 currently allows an association 90 days from the date the association files an application for registration with the board to establish and adopt a complaint process. The 90-day grace period for establishment of the complaint process was intended to allow new associations time to establish the mandated complaint process; however, some associations are registering that have been in existence for many years, but have never registered with the board. This amendment will provide homeowner protection by ensuring that associations have a complaint process regardless of their registration status.

Substance: The proposed regulation amends 18VAC48-70-40 by removing the provision applicable to associations registered with the board before July 1, 2012, as the subsection is no longer relevant. In addition, the proposed regulation allows 90 days for establishing a complaint procedure for new associations, but requires any other association filing an initial application to certify that an association complaint procedure has been established and adopted at the time the registration application is filed.

Issues: The primary advantage to the public is that the revisions will improve clarity of the regulations as they pertain to establishment of the complaint process and provide additional homeowner protection by making clear that the establishment of a complaint procedure is not related to the association's registration status. There are no identified disadvantages to the public.

The advantage to the Commonwealth is twofold: (i) the change reflects the importance that is placed on ensuring homeowners have access to a complaint process in which to

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have their grievances addressed prior to filing any complaint with the Office of the Common Interest Community Ombudsman and (ii) the change eliminates any discrepancy between statute and the board's current regulations regarding the status of registrations and the requirement to have a complaint process. No disadvantage for the Commonwealth has been identified.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Common Interest Community Board (Board) proposes to amend its ombudsman regulations to clarify that new co-op associations, condominium associations and property owner associations have to establish and adopt complaint procedures within 90 days of filing with the Board but that existing associations must have complaint procedures in place when they register with the Board.

Result of Analysis. Benefits likely outweigh costs for these proposed changes.

Estimated Economic Impact. Current regulation requires that associations "filing an initial application for registration must certify that an association complaint procedure has been, or will be, established and adopted by the governing board within 90 days of such filing." Board staff reports that the intent of the Board was that only new associations would have 90 days after filing to adopt complaint procedures but that existing associations would already have adopted complaint procedures and would not need an extra 90 days.

To clarify this language for regulated entities, the Board now proposes to split this requirement into two parts and only include the 90-day allowance in the part that addresses new associations. As this is not a substantive change, no entities are likely to incur costs on account of the proposed regulation. To the extent that these changes make the requirements of the Board more clear, interested parties will benefit from having a regulation that is more easily understood.

Businesses and Entities Affected. Board staff estimates that there are approximately 5,900 community associations registered with the Board. All of these entities, as well as any future registrants, will be affected by this proposed regulation.

Localities Particularly Affected. No locality will be particularly affected by this regulatory change.

Projected Impact on Employment. This proposed regulation is unlikely to have any impact on employment in the Commonwealth.

Effects on the Use and Value of Private Property. This proposed regulation is unlikely to have any impact on the use or value of private property.

Real Estate Development Costs. This proposed regulation is unlikely to affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. Small businesses in the Commonwealth are unlikely to incur any costs on account of this proposed regulation.

Alternative Method that Minimizes Adverse Impact. Small businesses in the Commonwealth are unlikely to incur any costs on account of this proposed regulation.

Adverse Impacts:

Businesses. Businesses in the Commonwealth are unlikely to incur any costs on account of this proposed regulation.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of this proposed regulatory change.

Other Entities. No other entities are likely to suffer any adverse impact on account of this proposed regulation.

Agency's Response to Economic Impact Analysis: The Common Interest Community Board concurs with the Department of Planning and Budget's economic impact analysis.

Summary:

The proposed amendments clarify that new condominium, cooperative, and property owners' associations must establish and adopt complaint procedures within 90 days of filing with the Common Interest Community Board, but that existing associations must have complaint procedures in place when they register with the board.

18VAC48-70-40. Establishment and adoption of written association complaint procedure.

~~A. Associations registered with the board before July 1, 2012, shall establish and adopt an association complaint procedure within 90 days of July 1, 2012.~~

~~B. A. Associations filing an initial application for registration pursuant to § 55-79.93:1, 55-504.1, or 55-516.1 of the Code of Virginia must certify that an association complaint procedure has been established and adopted at the date of registering or will be established and adopted by the governing board within 90 days of such filing registering with the board.~~

B. An association that has been delinquent in registering the association and filing its required annual reports is still required to have an established and adopted written association complaint procedure. At the time such an association files an application for registration, it must certify that an association complaint procedure has been established and adopted by the governing board.

C. The association shall certify with each annual report filing that the association complaint procedure has been adopted and is in effect.

V.A.R. Doc. No. R16-4523; Filed August 30, 2016, 12:15 p.m.

BOARD OF HEALTH PROFESSIONS

Final Regulation

REGISTRAR'S NOTICE: The Board of Health Professions is claiming an exclusion from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Board of Health Professions will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 18VAC75-30. Regulations Governing Standards for Dietitians and Nutritionists (repealing 18VAC75-30-10).

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Elizabeth A. Carter, Ph.D., Executive Director, Board of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4426, FAX (804) 527-4466, or email elizabeth.carter@dhp.virginia.gov.

Summary:

Section 54.1-2731 of the Code of Virginia authorizes the Board of Health Professions to establish qualifications, in addition to those set out in the law, by which a person may use the title dietitian or nutritionist. The criteria for use of the title currently in 18VAC75-30-10 were incorporated into § 54.1-2731 by Chapter 91 of the 2016 Acts of the Assembly. This action repeals 18VAC75-30 because the chapter is no longer needed.

V.A.R. Doc. No. R17-4851; Filed August 30, 2016, 10:04 a.m.



TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Final Regulation

Title of Regulation: 22VAC30-50. Policies and Procedures for Administering the Commonwealth Neurotrauma Initiative Trust Fund (amending 22VAC30-50-10, 22VAC30-50-20, 22VAC30-50-30, 22VAC30-50-50 through 22VAC30-50-120).

Statutory Authority: §§ 51.5-131 and 51.5-181 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Vanessa S. Rakestraw, Ph.D., CRC, Policy Analyst, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7612, FAX (804) 662-7663, TTY (800) 464-9950, or email vanessa.rakestraw@dars.virginia.gov.

Summary:

The amendments (i) clarify that requests for proposals shall be issued at the discretion of the Commonwealth Neurotrauma Initiative Advisory Board and shall depend upon the availability of funds; (ii) emphasize that grants provided by the fund are not to be used for long-term funding of research or community based rehabilitative programs; (iii) require that applicants for grants under this fund provide a plan for sustaining the proposed project following the termination of the grant award; and (iv) make technical corrections, update statutory references, and make other necessary changes.

Summary of Public Comments and Agency's Response: No public comments were received by the promulgating agency.

Part I

Definitions and General Information

22VAC30-50-10. Definitions.

The following words and terms when used in this chapter shall have the following ~~meaning~~ meanings unless the context clearly indicates otherwise:

"Advisory board" means the Commonwealth Neurotrauma Initiative Advisory Board.

"Commissioner" means the Commissioner of the Department for Aging and Rehabilitative Services.

"Department" means the Department for Aging and Rehabilitative Services.

"Fund" means the Commonwealth Neurotrauma Initiative Trust Fund.

"Neurotrauma" means an injury to the central nervous system, ~~i.e.~~ (i.e., a traumatic spinal cord or brain injury, ~~which injury~~) that results in loss of physical functions, cognitive functions, or both.

"RFP" ~~or "request"~~ means a request for proposals issued by the advisory board seeking applications for grant moneys in the fund.

22VAC30-50-20. Statement of general policy.

The Commonwealth of Virginia has recognized the need to prevent traumatic spinal cord and brain injuries and is committed to improving the treatment and care of Virginians with traumatic spinal cord and brain injuries. By creating the fund and authorizing the advisory board to administer the fund, the Commonwealth of Virginia makes grant funds available to Virginia-based organizations, institutions, and researchers to address these needs. The advisory board administers the fund to carry out the intent of the law in accordance with its authority.

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22VAC30-50-30. Disbursement of funds.

A. This chapter serves to (i) establish policies and procedures for soliciting and receiving applications for grants from the fund, (ii) establish criteria for reviewing and ranking such applications, and (iii) establish procedures for distributing moneys in the fund, which shall be used solely to provide grants to Virginia-based organizations, institutions, and researchers.

B. Forty-seven and one-half percent of the moneys in the fund distributed under this chapter shall be allocated for research on the mechanisms and treatment of neurotrauma; 47-1/2% of the moneys shall be allocated for rehabilitative services, ~~i.e.~~ (i.e., the development of innovative, model community-based rehabilitative programs and services for individuals with neurotrauma); and 5.0% of the moneys shall be allocated for the ~~Department for Aging and Rehabilitative Services'~~ Department for Aging and Rehabilitative Services' department's costs for administering and staffing the ~~Commonwealth Neurotrauma Initiative Trust Fund~~ fund and advisory board.

22VAC30-50-50. Application of exemption to the Virginia Freedom of Information Act.

Pursuant to ~~a provision~~ subdivision 12 of § 2.2-3705.5 of the Virginia Freedom of Information Act, Chapter 37 (§ 2.2-3700 et seq.) of Title 2.2 of the Code of Virginia, records submitted to the advisory board as a grant application, or accompanying a grant application, pursuant to ~~the law [Chapter 14 Article 12]~~ (§ 51.5-178 et seq.) ~~[of Chapter 14]~~ [of Title 51.5 of the Code of Virginia and this chapter are excluded from the requirement of open inspection to the extent that they contain medical or mental health records or other data identifying individual patients, or proprietary business or research-related information produced or collected by an applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical, or scholarly issues. This exemption shall apply when ~~such~~ the information has not been publicly released, published, copyrighted, or patented, if the disclosure of ~~such~~ the information would be harmful to the competitive position of the applicant. The advisory board intends to rely upon this exemption in order to encourage the submission of applications.

Part II

Soliciting and Reviewing Applications

22VAC30-50-60. Requests for proposals.

The advisory board ~~will~~ shall solicit applications for grants of moneys from the fund by issuing ~~requests for proposals~~ RFPs from time to time. These RFPs shall be issued at the discretion of the advisory board and shall depend upon the availability of moneys in the fund. Each application for a grant must be ~~received~~ submitted in response to an actual ~~request for a proposal~~ RFP and received by a deadline specified in the ~~request~~ RFP.

22VAC30-50-70. Grant reviewers and technical advisors.

The advisory board may choose, at any time, to appoint grant reviewers or other technical advisors, or both, to assist in reviewing and ranking applications. Such reviewers and advisors may represent medical researchers, medical practitioners, community-based service providers, consumers, advocates for consumers, or others deemed appropriate by the advisory board for this purpose. Reviewers and advisors shall be appointed so as to provide equal representation from Virginia's three medical schools. Reviewers and advisors shall be selected so as to avoid any conflict of interests or the appearance thereof, and the advisory board may choose reviewers and advisors residing or working outside Virginia to ensure impartiality. Whenever reviewers or advisors sit as a committee, the ~~chairman~~ chair of the advisory board or his designee shall serve as ~~chairman~~ chair of the committee but shall not vote on individual applications.

22VAC30-50-80. Specification of Option A or B.

Each application shall clearly state a purpose to seek funds for projects to conduct research on the mechanisms and treatment of neurotrauma, which shall be referred to as "Option A," or to develop innovative, model community-based rehabilitative programs and services for individuals with neurotrauma, which shall be referred to as "Option B." Option A applications shall state and demonstrate a clear intention of researching the mechanisms of neurotrauma or the treatment of neurotrauma, or both. Option B applications shall state and demonstrate a clear intention to provide innovative, model community-based rehabilitative services by developing, expanding, evaluating, or improving community-based programs and services for people with traumatic brain injury or traumatic spinal cord injury, or both, and expanding opportunities for ~~such~~ these individuals to become as independent and physically and functionally capable as possible. Neither Option A nor Option B grants ~~are intended~~ shall be used for long-term funding of research projects or service community-based rehabilitative programs and services.

22VAC30-50-90. Submission of applications.

In reviewing applications submitted for grant awards, whether Option A or Option B, the advisory board ~~will~~ shall accept applications that:

1. Present a clear and convincing ~~and persuasive~~ discussion of how the proposed project ~~will~~ shall carry out its intention as specified in accordance with 22VAC30-50-80; and describe in as much detail as possible its anticipated effectiveness in carrying out its intention;
2. Comply fully with informational and administrative requirements stated in the specific RFP to which applicants are responding; and
3. In the case of an Option A application:
 - a. Discuss the relevance of the proposed project to an identified field of medical or rehabilitative inquiry;

- b. Demonstrate the anticipated benefit of the proposed project in terms of expanding knowledge and understanding of neurotrauma;
 - c. Discuss any innovation or breakthrough the project seeks to promote, specifying outcome measures where possible for each of the preceding enumerated items in this subdivision; ~~and~~
 - d. Describe efforts to ensure that the proposed project does not duplicate previous or ongoing research; ~~or and~~
 - e. Provide a plan for sustaining the proposed project following termination of a grant award as relevant to the intention of the proposed project; or
4. In the case of an Option B application:
- a. Discuss the relevance of the proposed project to an identified need for innovative, model community-based rehabilitative programs and services in terms of the absence of alternative ~~programs, services, and~~ resources available to the intended individuals and community;
 - b. Describe efforts to ensure that the proposed project does not duplicate existing programs, services, or resources already available to targeted individuals and communities; and
 - c. ~~State and emphasize~~ Demonstrate a commitment to collaborative community planning involving consumer groups, service providers, employers, relevant state and local agencies, and other funding sources, as available ~~or anticipated to become available. and appropriate; and~~
 - d. Provide a plan for sustaining the proposed project following termination of a grant award as relevant to the intention of the proposed project.

Part III

Specific Project Consideration and Application Criteria,
Selection of Successful Applications and Amount and
Announcement of Awards

22VAC30-50-100. Reviewing and ranking grant applications.

A. The advisory board ~~will shall~~ distinguish the class of Option A applications from the class of Option B applications when soliciting, reviewing, and ranking grant applications. Applications ~~will shall~~ be considered and ranked only among other applications submitted under the same stated option, either Option A or Option B. Applications initially deemed ~~effective in meeting to meet~~ the purpose of a solicitation and to have substantially addressed the general considerations stated in ~~Part II (22VAC30-50-60 et seq.) of this chapter~~ 22VAC30-50-60 through 22VAC30-50-90, as applicable, ~~will shall~~ be subsequently reviewed and ranked according to the following criteria:

- 1. The purpose and significance of the project;
- 2. The objectives and expected benefits of the project;
- 3. The design of the project to include (i) methods, activities, and a timeline for achieving project goals and

- objectives, and (ii) a system for measuring outcomes and documenting project impact, effectiveness, and any anticipated long-term effects;
- 4. A detailed budget that is reasonable and appropriate for the scope of the project;
- 5. The identification of potential sources of funds and fundraising strategies to be used in sustaining the proposed project following termination of a grant award as relevant to the intention of the proposed project;
- 6. Demonstrated or anticipated capability of the existing or planned organizational structure;
- 7. The means for consumer involvement in the design, implementation, and evaluation of the project as feasible and relevant to the intention of the proposed project; and
- 8. A commitment to include the participation of small, women-owned and minority businesses, as such are available and capable of participation.

B. When initially reviewing applications or subsequently reviewing and ranking applications, the advisory board may ask ~~applicants an applicant~~ to provide required information that is missing from the application or additional clarifying information relating to ~~their applications the application~~ and proposed ~~projects project~~. Failure to provide missing information or failure to provide additional information that is material and relevant may result in the rejection or lowered ranking of an application.

22VAC30-50-110. Amount of grant awards; duration and availability of funding.

A. After reviewing all applications, duly ~~received accepted~~, for either Option A or Option B, the advisory board ~~will shall~~ determine ~~which the~~ proposed projects ~~will that shall~~ be offered funding. The selection of successful applications ~~will shall~~ be made based on (i) availability of moneys in the fund, (ii) the review and ranking of the applications according to the criteria listed in ~~this chapter~~ 22VAC30-50-100 A, (iii) information from grant reviewers or technical advisors ~~who~~ appointed by the board ~~may appoint~~ to assist in evaluating applications, and (iv) the advisory board's assessment of ~~those~~ the applications, as to which further the intentions and the purpose of the fund. Discussions and negotiations may be conducted between the advisory board and grant applicants in order to clarify any remaining issues relating to the proposed project.

B. In ~~considering and~~ determining the amount of a grant award and the duration of funding for a particular project, the advisory board ~~will shall~~ consider the requested amount, the project design, and justification. ~~Actual grant~~ Grant awards ~~will be made in amounts ranging shall range in amount~~ from \$5,000 to \$150,000 per year for an anticipated funding period of one to three years as described in the ~~proposal~~ RFP. The award and duration of funding of a project anticipated to exceed one year ~~will shall~~ be contingent upon (i) the availability of moneys in the fund, whether so stated at the

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time of the award or not, and (ii) the grantee's successful completion of timelines and of interim objectives and milestones as proposed and approved in the grant application, grant award, and contract documents.

C. In the event any timelines and interim objectives and milestones pertaining to a project are not completed to the satisfaction of the advisory board, the advisory board may act to withhold moneys not yet disbursed for ~~such a~~ the project. In the event of a ~~substantial~~ decline in moneys in the fund, the advisory board ~~will~~ shall attempt to distribute moneys ~~to projects of an anticipated duration greater than one year~~ in a manner as fair and equitable as possible.

D. The award of grants to successful applicants ~~will~~ shall be made public within 60 days of the advisory board's decision regarding all applications submitted in response to ~~a request for proposals~~ an RFP.

22VAC30-50-120. Unexpended funds.

~~Notwithstanding any other law to the contrary, the Commissioner of the Department for Aging and Rehabilitative Services~~ commissioner may reallocate up to \$500,000 from unexpended balances in the ~~Commonwealth Neurotrauma Initiative Trust Fund~~ to fund for new grant awards for research on traumatic brain and spinal cord injuries.

VA.R. Doc. No. R14-3419; Filed August 19, 2016, 3:23 p.m.

Final Regulation

Title of Regulation: 22VAC30-70. The Virginia Public Guardian and Conservator Program (amending 22VAC30-70-30).

Statutory Authority: §§ 51.5-131 and 51.5-150 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Vanessa S. Rakestraw, Ph.D., CRC, Policy Analyst, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7612, FAX (804) 662-7663, TTY (800) 464-9950, or email vanessa.rakestraw@dars.virginia.gov.

Summary:

As mandated by Chapter 322 of the 2012 Acts of the Assembly, the amendments require person-centered planning that (i) focuses on the preferences, personal values, and needs of the individual receiving public guardianship services and (ii) directs public guardianship services to empower and support the individual receiving services in defining the direction for his life and promoting self-determination and community involvement. A change since publication of the proposed regulation requires, to the maximum extent feasible, that the person-centered planning process for an individual receiving case management services licensed or funded by the Department of Behavioral Health and Developmental Services include participation and collaboration among

the guardian or conservator, case managers, and providers in meeting the individual's planning goals in conformity with the guardian or conservator's court order.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

22VAC30-70-30. Public guardian programs.

A. Designation. The department shall select public guardian programs in accordance with the requirements of the Virginia Public Procurement Act. Only those programs that contract with the department ~~will~~ shall be designated as public guardian programs. Funding for public guardian programs is provided by the appropriation of general funds.

B. Authority. A public guardian program appointed as a guardian, a conservator, or both as a guardian and conservator, shall have all the powers and duties specified in ~~Article 1 (§ 37.2-1000 et seq.) of Chapter 10 of Title 37.2~~ Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 of the Code of Virginia, except as otherwise specifically limited by a court.

C. Structure.

1. Each public guardian program shall have a program director who supervises and is responsible for providing guardianship services to any incapacitated persons assigned by the court and to provide overall administration for the public guardian program. The program director ~~must~~ shall be a full-time employee of the program and have experience as a service provider or administrator in one or more of the following areas: social work, case management, mental health, nursing or other human service programs. The program director ~~must~~ shall also demonstrate, by objective criteria, a knowledge and understanding of Virginia's guardianship laws, alternatives to guardianship, and surrogate decision making activities. The program director shall attend all training and activities required by the department.

2. Each public guardian program shall establish a multidisciplinary panel to (i) screen cases for the purpose of ensuring that appointment of a guardian or conservator is appropriate under the circumstances and is the least restrictive alternative available to assist the incapacitated person. This screening shall include a duty to recommend the most appropriate limitations on the power of the guardian or conservator, if any, to ensure that the powers and duties assigned are the least restrictive, and (ii) annually review cases being handled by the program to ensure that a guardian or conservator appointment remains appropriate. Composition of a multidisciplinary panel should include representatives from various human services agencies serving the city, county, or region where the public guardian program accepts referrals. If serving a region, the multidisciplinary panel shall have at least one representative from each local jurisdiction within the region. To the extent appropriate disciplines are available,

this panel should include but is not limited to representation from:

- a. Local departments of social services, adult protective services;
- b. Community services boards or behavioral health authorities;
- c. ~~An attorney~~ Attorneys licensed by the Virginia State Bar;
- d. Area agencies on aging;
- e. Local health departments;
- f. Nursing home, assisted living, and group home administrators; and
- g. Physicians and community representatives.

D. Client ratio to paid staff.

1. Each public guardian program shall maintain a direct service ratio of clients to paid staff that does not exceed the department's established ideal ratio of 20 incapacitated persons to every one paid full-time staff person 20:1.
2. Each public guardian program shall have in place a plan to immediately provide notice to the circuit ~~court(s)~~ court or courts in its jurisdiction and to the department when the program determines that it may exceed its ideal ratio of clients to paid staff.
3. In an emergency or unusual circumstance, each program, in its discretion, may exceed the department's established ideal ratio by no more than five additional incapacitated persons. Each program shall have in place a policy to immediately provide notice to the department when such an emergency or unusual circumstance occurs and when the emergency or unusual circumstance ends and the ideal ratio has returned to 20:1. The notice to the department shall comply with policy established by the department. Other than an emergency or unusual circumstance as described in the preceding sentence, a waiver must be requested to exceed the department's established ideal ratio. The department, in consultation with the advisory board, shall establish written procedures for public guardian programs to obtain appropriate waivers regarding deviations in the ideal ratio of clients to paid staff. Procedures shall comply with §§ 51.5-150 and 51.5-151 of the Code of Virginia. The department shall report waiver requests and status of granted waivers to the advisory board at its regularly scheduled meetings. The department shall review such waivers every six months to ensure that there is no immediate threat to the person or property of any incapacitated person nor that exceeding the department's established ideal ratio is having or will have a material and adverse effect on the ability of the program to properly serve all of the incapacitated persons it has been designated to serve.

E. Appointments.

1. Prior to the public guardian program accepting an individual for services, the multidisciplinary panel described in ~~22VAC30-70-30~~ subdivision C 2 of this section shall screen referrals to ensure that:
 - a. The public guardian program is appointed as guardian, or conservator, or both only in those cases where guardianship or conservatorship is the least restrictive alternative available to assist the individual;
 - b. The appointment is consistent with serving the type of client identified by the established priorities of the public guardian program;
 - c. The individual cannot adequately care for himself;
 - d. The individual is indigent; and
 - e. There is no other proper or suitable person or entity to serve as guardian.
 - f. In the case of an individual who receives case management services from a community services board (CSB) or behavioral health authority (BHA), the multidisciplinary panel may also request the results of the "determination of capacity" as authorized by 12VAC35-115-145 (Determination of capacity to give consent or authorization) and verification that no other person is available or willing to serve as guardian pursuant to 12VAC35-115-146 E (Authorized representatives).
2. Appointments by a circuit court shall name the public guardian program, rather than an individual person, as the guardian, the conservator or both guardian and conservator.
3. A public guardian program shall only accept appointments as guardian, conservator, or both guardian and conservator that generate no fee or that generate a minimal fee.

F. Services.

1. A public guardian program shall have a continuing duty to seek a proper and suitable person who is willing and able to serve as guardian, conservator, or both guardian and conservator for the incapacitated person.
2. The guardian or conservator shall encourage the incapacitated person to participate in decisions, to act on his own behalf, and to develop or regain the capacity to manage his personal affairs to the extent feasible.
3. The guardian or conservator shall be guided by person-centered planning that:
 - a. Focuses on the expressed preferences, personal values, and needs of the individual receiving public guardian program services; and
 - b. Empowers and supports the individual receiving public guardian program services, to the extent feasible, in defining the direction for his life and promoting self-determination and community involvement.

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4. To the maximum extent feasible, the person-centered planning process shall:

a. Include people chosen by the individual;

b. Provide necessary information and support to enable the individual to direct the process and to make informed choices and decisions;

c. Be timely and occur at times and locations convenient for the individual;

[d. Require participation and collaboration, in the case of an individual receiving case management services licensed or funded by the Department of Behavioral Health and Developmental Services, among the guardian or conservator, case managers, and providers in meeting the individual's planning goals, in conformity with the guardian or conservator's court order;

~~d. e.~~] Reflect the individual's cultural values;

[e. f.] Offer choices to the individual regarding the services the individual receives and from whom the individual receives those services; and

[~~f.~~ g.] Include documentation of processes employed in and the outcomes of person-centered planning.

~~3.~~ 5. The multidisciplinary panel described in 22VAC30-70 ~~30~~ subdivision C 2 of this section shall review active cases at least once every 12 months to determine that:

a. The client continues to be incapacitated;

b. The client continues to be indigent; and

c. There is no other proper or suitable person or entity to serve as guardian, conservator, or both guardian and conservator.

~~4.~~ 6. Each public guardian program shall set priorities with regard to services to be provided to incapacitated persons in accordance with its contract with the department.

~~5.~~ 7. Each public guardian program shall develop written procedures and standards to make end-of-life decisions or other health-related interventions in accordance with the expressed desires and personal values of the incapacitated person to the extent known. If expressed desires or personal values are unknown, then written procedures, including an ethical decision-making process, shall be used to ensure that the guardian or conservator acts in the incapacitated person's best interest and exercises reasonable care, diligence and prudence on behalf of the client.

~~6.~~ 8. The public guardian program shall avoid even the appearance of a conflict of interest or impropriety when dealing with the needs of the incapacitated person. Impropriety or conflict of interest arises where the public guardian program has some personal or agency interest that might be perceived as self-serving or adverse to the position or the best interest of the incapacitated person. Examples include, but are not limited to, situations where the public guardian program provides services such as

housing, hospice or medical care directly to the client. The department reserves the right to monitor all administrative, programmatic, and financial activities related to the public guardian program to ensure compliance with the terms of the contract between the department and the public guardian program.

~~7.~~ 9. Each public guardian program and its employees are required to report any suspected abuse, neglect, or exploitation in accordance with § 63.2-1606 of the Code of Virginia, ~~that~~ which provides for the protection of aged or incapacitated adults, mandates reporting, and provides for a penalty for failure to report.

~~8.~~ 10. Each public guardian program shall submit data and reports as required by the department and maintain compliance with the department's program guidelines. The department shall periodically monitor administrative, programmatic, and financial activities related to the public guardian program, including person-centered planning utilization and documentation, to ensure compliance with the terms of the contract between the public guardian program and the department.

VA.R. Doc. No. R13-3565; Filed August 19, 2016, 3:16 p.m.

STATE BOARD OF SOCIAL SERVICES

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **22VAC40-41. Neighborhood Assistance Tax Credit Program (amending 22VAC40-41-10, 22VAC40-41-20).**

Statutory Authority: §§ 58.1-439.20 and 63.2-217 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Wanda Stevenson, Neighborhood Assistance Program Technician, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7924, or email wanda.stevenson@dss.virginia.gov.

Summary:

Pursuant to Chapter 426 of the 2016 Acts of Assembly, the amendments (i) change "Commissioner of the State Department of Social Services" to "Commissioner of Social Services," (ii) add requirements for any affiliate of a neighborhood organization that must be fulfilled for the organization to be approved to accept tax deductible

donations for neighborhood assistance programs, and (iii) create an exception to those requirements.

22VAC40-41-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Affiliate" means with respect to any person, any other person directly or indirectly controlling, controlled by, or under common control with such person. For purposes of this definition, "control" (including controlled by and under common control with) means the power, directly or indirectly, to direct or cause the direction of the management and policies of such person whether through ownership or voting securities or by contract or otherwise.

"Approved organization" means a neighborhood organization that has been found eligible to participate in the Neighborhood Assistance Program.

"Audit" means any audit required under the federal Office of Management and Budget's Circular A-133, or, if a neighborhood organization is not required to file an audit under Circular A-133, a detailed financial statement prepared by an outside independent certified public accountant.

"Business firm" means any corporation, partnership, electing small business (Subchapter S) corporation, limited liability company, or sole proprietorship authorized to do business in this Commonwealth subject to tax imposed by Articles 2 (§ 58.1-320 et seq.) and 10 (§ 58.1-400 et seq.) of Chapter 3, Chapter 12 (§ 58.1-1200 et seq.), Article 1 (§ 58.1-2500 et seq.) of Chapter 25, or Article 2 (§ 58.1-2620 et seq.) of Chapter 26 of Title 58.1 of the Code of Virginia. "Business firm" also means any trust or fiduciary for a trust subject to tax imposed by Article 6 (§ 58.1-360 et seq.) of Chapter 3 of Title 58.1 of the Code of Virginia.

"Commissioner" means the Commissioner of ~~the Department of Social Services~~, his designee or authorized representative.

"Community services" means any type of counseling and advice, emergency assistance, medical care, provision of basic necessities, or services designed to minimize the effects of poverty, furnished primarily to low-income persons.

"Contracting services" means the provision, by a business firm licensed by the Commonwealth of Virginia as a contractor under Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1 of the Code of Virginia, of labor or technical advice to aid in the development, construction, renovation, or repair of (i) homes of low-income persons or (ii) buildings used by neighborhood organizations.

"Education" means any type of scholastic instruction or scholastic assistance to a low-income person or eligible student with a disability.

"Eligible student with a disability" means a student (i) for whom an individualized educational program has been written and finalized in accordance with the federal

Individuals with Disabilities Education Act (IDEA), regulations promulgated pursuant to IDEA, and regulations of the Board of Education and (ii) whose family's annual household income is not in excess of 400% of the current poverty guidelines.

"Housing assistance" means furnishing financial assistance, labor, material, or technical advice to aid the physical improvement of the homes of low-income persons.

"Job training" means any type of instruction to an individual who is a low-income person that enables him to acquire vocational skills so that he can become employable or able to seek a higher grade of employment.

"Low-income person" means an individual whose family's annual household income is not in excess of 300% of the current poverty guidelines.

"Neighborhood assistance" means providing community services, education, housing assistance, or job training.

"Neighborhood organization" means any local, regional or statewide organization whose primary function is providing neighborhood assistance and holding a ruling from the Internal Revenue Service of the U.S. Department of the Treasury that the organization is exempt from income taxation under the provisions of § 501(c)(3) or § 501(c)(4) of the Internal Revenue Code of 1986, as amended from time to time, or any organization defined as a community action agency in the Economic Opportunity Act of 1964 (42 USC § 2701 et seq.), or any housing authority as defined in § 36-3 of the Code of Virginia.

"Poverty guidelines" means the poverty guidelines for the 48 contiguous states and the District of Columbia updated annually in the Federal Register by the U.S. Department of Health and Human Services under the authority of § 673(2) of the Omnibus Budget Reconciliation Act of 1981.

"Professional services" means any type of personal service to the public which requires as a condition precedent to the rendering of such service the obtaining of a license or other legal authorization and shall include, but not be limited to, the personal services rendered by medical doctors, dentists, architects, professional engineers, certified public accountants, attorneys-at-law, and veterinarians.

"Scholastic assistance" means (i) counseling or supportive services to elementary school, middle school, secondary school, or postsecondary school students or their parents in developing a postsecondary academic or vocational education plan, including college financial options for such students or their parents, or (ii) scholarships.

22VAC40-41-20. Purpose; procedure for becoming an approved organization; eligibility criteria; termination of approved organization; appeal procedure.

A. The purpose of the Neighborhood Assistance Program is to encourage business firms and individuals to make donations to neighborhood organizations for the benefit of low-income persons.

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B. Neighborhood organizations that do not provide education services and that wish to become an approved organization must submit an application to the commissioner. Neighborhood organizations that provide education services must submit an application to the Superintendent of Public Instruction. The application submitted to the Superintendent of Public Instruction must comply with regulations or guidelines adopted by the Board of Education. The application submitted to the commissioner must contain the following information:

1. A description of eligibility as a neighborhood organization, the programs being conducted, the low-income persons assisted, the estimated amount that will be donated to the programs, and plans for implementing the programs.
2. Proof of the neighborhood organization's current exemption from income taxation under the provisions of § 501(c)(3) or § 501(c)(4) of the Internal Revenue Code, or the organization's eligibility as a community action agency as defined in the Economic Opportunity Act of 1964 (42 USC § 2701 et seq.) or housing authority as defined in § 36-3 of the Code of Virginia.
3. For neighborhood organizations with total revenues (including the value of all donations) (i) in excess of \$100,000 for the organization's most recent year ended, an audit or review for such year performed by an independent certified public accountant or (ii) of \$100,000 or less for the organization's most recent year ended, a compilation for such year performed by an independent certified public accountant; a copy of the organization's current federal form 990; a current brochure describing the organization's programs; and a copy of the annual report filed with the Department of Agriculture and Consumer Services' Division of Consumer Protection.
4. A statement of objective and measurable outcomes that are expected to occur and the method the organization will use to evaluate the program's effectiveness.

C. To be eligible for participation in the Neighborhood Assistance Program, the applicant and any of its affiliates must meet the following criteria:

1. Applicants must have been in operation as a viable entity, providing neighborhood assistance for low-income people, for at least 12 months.
2. Applicants must be able to demonstrate that at least 50% of the total people served and at least 50% of the total expenditures were for low-income persons or eligible students with disabilities.
3. Applicant's audit must not contain any significant findings or areas of concern for the ongoing operation of the neighborhood organization.
4. Applicants must demonstrate that at least 75% of total revenue received is expended to support their ongoing programs each year.

D. Beginning with tax credit allocations for fiscal year 2016-2017, the applicant and any of its affiliates must meet the following requirements:

1. Affiliates of neighborhood organizations must demonstrate that at least 50% of the persons served are low-income persons;
2. Affiliates of neighborhood organizations must demonstrate that at least 50% of the revenues are used to provide services to such persons;
3. Affiliates must also meet the definition of "neighborhood organization" under § 58.1-439.18 of the Code of Virginia; and
4. Affiliates are not required to submit an audit, review, or compilation, and such reports shall not apply in determining the eligibility of the neighborhood organization submitting a proposal.

E. Requirements in subsection D of this section do not apply to a neighborhood organization submitting a proposal and any of its affiliates, provided that:

1. The neighborhood organization otherwise meets all statutory requirements and regulations;
2. The neighborhood organization received a fiscal year 2013-2014 allocation of neighborhood assistance tax credits; and
3. No affiliate of the neighborhood organization submits a proposal for or receives an allocation of tax credits pursuant to this chapter for the program year for which the neighborhood organization has submitted its proposal.

~~D. F.~~ The application period will start no later than March 15 of each year. All applications must be received by the Department of Social Services no later than the first business day of May. An application filed without the required audit, review, or compilation will be considered timely filed provided that the audit, review, or compilation is filed within 30 days immediately following the deadline.

~~E. G.~~ Those applicants submitting all required information and reports and meeting the eligibility criteria described in this section will be determined an approved organization. The program year will run from July 1 through June 30 of the following year.

~~F. H.~~ The commissioner may terminate an approved organization's eligibility based on a finding of program abuse involving illegal activities or fraudulent reporting on contributions.

VA.R. Doc. No. R17-4713; Filed August 18, 2016, 10:46 a.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The

State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 22VAC40-72. Standards for Licensed Assisted Living Facilities (amending 22VAC40-72-340).

Statutory Authority: §§ 63.2-217 and 63.2-1732 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Judith McGreal, Program Consultant, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7157, or email judith.mcgreal@dss.virginia.gov.

Summary:

Pursuant to Chapter 598 of the 2016 Acts of Assembly, the amendment adds a requirement that an assisted living facility that does not provide or allow hospice care include such hospice care restrictions in a disclosure statement signed by the resident prior to admission.

Part V

Admission, Retention and Discharge of Residents

22VAC40-72-340. Admission and retention of residents.

A. No resident shall be admitted or retained:

1. For whom the facility cannot provide or secure appropriate care;
2. Who requires a level of care or service or type of service for which the facility is not licensed or which the facility does not provide; or
3. If the facility does not have staff appropriate in numbers and with appropriate skill to provide the care and services needed by the resident.

B. Assisted living facilities shall not admit an individual before a determination has been made that the facility can meet the needs of the resident. The facility shall make the determination based upon the following information at a minimum:

1. The completed UAI.
2. The physical examination report.
3. A documented interview between the administrator or a designee responsible for admission and retention decisions, the resident and his legal representative, if any. In some cases, medical conditions may create special circumstances that make it necessary to hold the interview on the date of admission.
4. A screening of psychological, behavioral, and emotional functioning, conducted by a qualified mental health professional, if recommended by the UAI assessor, a health care professional, or the administrator or designee responsible for the admission and retention decision. This includes meeting the requirements of 22VAC40-72-360.

C. An assisted living facility shall only admit or retain residents as permitted by its use and occupancy classification

and certificate of occupancy. The ambulatory/nonambulatory status of an individual is based upon:

1. Information contained in the physical examination report; and
2. Information contained in the most recent UAI.

D. Upon receiving the UAI prior to admission of a resident, the assisted living facility administrator shall provide written assurance to the resident that the facility has the appropriate license to meet his care needs at the time of admission. Copies of the written assurance shall be given to the legal representative and case manager, if any, and a copy signed by the resident or his legal representative shall be kept in the resident's record.

E. All residents shall be 18 years of age or older.

F. No person shall be admitted without his consent and agreement, or that of his legal representative with demonstrated legal authority to give such consent on his behalf.

G. Assisted living facilities shall not admit or retain individuals with any of the following conditions or care needs:

1. Ventilator dependency;
2. Dermal ulcers III and IV except those stage III ulcers that are determined by an independent physician to be healing, as permitted in subsection H of this section;
3. Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a health care professional licensed in Virginia as permitted in subsection I of this section or except as permitted in subsection J of this section;
4. Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold;
5. Psychotropic medications without appropriate diagnosis and treatment plans;
6. Nasogastric tubes;
7. Gastric tubes except when the individual is capable of independently feeding himself and caring for the tube or as permitted in subsection J of this section;
8. Individuals presenting an imminent physical threat or danger to self or others;
9. Individuals requiring continuous licensed nursing care;
10. Individuals whose physician certifies that placement is no longer appropriate;
11. Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance (12VAC30-10); or

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12. Individuals whose physical or mental health care needs cannot be met in the specific assisted living facility as determined by the facility.

H. When a resident has a stage III dermal ulcer that has been determined by an independent physician to be healing, periodic observation and any necessary dressing changes shall be performed by a licensed health care professional under a physician's or other prescriber's treatment plan.

I. Intermittent intravenous therapy may be provided to a resident for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician's or other prescriber's treatment plan. When a course of treatment is expected to be ongoing and extends beyond a two-week period, evaluation is required at two-week intervals by the licensed health care professional.

J. At the request of the resident in an assisted living facility and when his independent physician determines that it is appropriate, (i) care for the conditions or care needs specified in subdivisions G 3 and 7 of this section may be provided to the resident by a physician licensed in Virginia, a nurse licensed in Virginia or a nurse holding a multistate licensure privilege under a physician's or other prescriber's treatment plan, or a home care organization licensed in Virginia or (ii) care for the conditions or care needs specified in subdivision G 7 of this section may also be provided to the resident by unlicensed direct care facility staff if the care is delivered in accordance with the regulations of the Board of Nursing for delegation by a registered nurse, 18VAC90-20-420 through 18VAC90-20-460 and 22VAC40-72-460 D.

This standard does not apply to recipients of auxiliary grants.

K. When care for a resident's special medical needs is provided by licensed staff of a home care agency, the assisted living facility direct care staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency.

L. Notwithstanding § 63.2-1805 of the Code of Virginia, at the request of the resident, hospice care may be provided in an assisted living facility under the same requirements for hospice programs provided in Article 7 (§ 32.1-162.1 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia; if the hospice program determines that such program is appropriate for the resident. However, to the extent allowed by federal law, no assisted living facility shall be required to provide or allow hospice care if such hospice care restrictions are included in a disclosure statement that is signed by the resident prior to admission.

VA.R. Doc. No. R17-4734; Filed August 18, 2016, 10:47 a.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **22VAC40-90. Regulation for Background Checks for Assisted Living Facilities and Adult Day Care Centers (amending 22VAC40-90-40).**

Statutory Authority: § 63.2-217 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Judith McGreal, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7157, FAX (804) 726-7132, or email judith.mcgreal@dss.virginia.gov.

Summary:

Pursuant to Chapter 632 of the 2016 Acts of Assembly, the amendment adds a requirement that no assisted living facility or adult day care center shall continue to employ any person who has a conviction of any barrier crime. Currently a facility is prohibited from hiring an individual who has been convicted of a barrier crime.

Part III

The Criminal History Record Report

22VAC40-90-40. General requirements.

A. The applicant for licensure shall submit a criminal history record report upon application for licensure as an assisted living facility.

B. The criminal history record report shall be obtained on or prior to the 30th day of employment for each employee.

C. Any person required by this chapter to obtain a criminal history record report shall be ineligible for employment if the report contains convictions of the barrier crimes.

D. If a criminal history record is requested, it shall be the responsibility of the licensee to ensure that the employee has not been convicted of any of the barrier crimes.

E. Criminal history record reports shall be kept confidential. Reports on employees shall only be received by the facility administrator, licensee, board president, or their designee.

F. A criminal history record report issued by the State Police shall not be accepted by the facility if the report is dated more than 90 days prior to the date of employment.

G. Any applicant denied licensure as an assisted living facility or employment at an assisted living facility or adult day care center because of convictions appearing on his criminal history record report shall be provided a copy of the report by the licensing authority or the hiring facility.

H. A facility shall not continue to employ any person who has a conviction of any of the barrier crimes.

V.A.R. Doc. No. R17-4735; Filed August 18, 2016, 10:48 a.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 22VAC40-111. Standards for Licensed Family Day Homes (amending 22VAC40-111-10).

Statutory Authority: §§ 63.2-217 and 63.2-1734 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Sharon Smith-Basey, Program Consultant, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7037, FAX (804) 726-7132, or email sharon.basey@dss.virginia.gov.

Summary:

Pursuant to Chapters 758 and 770 of the 2015 Acts of Assembly, the amendments change the definition of "family day home" to lower the threshold required for licensure to five children at any one time, exclusive of the provider's own children and any children residing in the home.

22VAC40-111-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Accessible" means capable of being entered, reached, or used.

"Adult" means any individual 18 years of age or older.

"Age-appropriate" means suitable to the chronological age and individual needs of a child.

"Assistant" means an individual who helps the provider or substitute provider in the care, protection, supervision, and guidance to children in the home.

"Body fluids" means urine, feces, vomit, blood, saliva, nasal discharge, and tissue discharge.

"Caregiver" means an individual who provides care, protection, supervision, and guidance to children in the home and includes the provider, substitute provider, and assistant.

"Child" means an individual under 18 years of age.

"Child day program" means a regularly operating service arrangement for children where, during the absence of a parent or guardian, a person or organization has agreed to assume responsibility for the supervision, protection, and

well-being of a child under the age of 13 for less than a 24-hour period.

"Child with special needs" means a child with developmental disabilities, ~~mental retardation~~ intellectual disabilities, emotional disturbance, sensory or motor impairment, or significant chronic illness who requires special health surveillance or specialized programs, interventions, technologies, or facilities.

"Cleaned" means treated in such a way as to remove dirt and debris by scrubbing and washing with soap and water or detergent solution and rinsing with water.

"Commissioner" means the Commissioner of the Virginia Department of Social Services.

"Department" means the Virginia Department of Social Services.

"Department's representative" means an employee or designee of the Virginia Department of Social Services, acting as the authorized agent of the commissioner.

"Evacuation" means movement of occupants out of the building to a safe area near the building.

"Family day home" means a child day program offered in the residence of the provider or the home of any of the children in care for one through 12 children under the age of 13, exclusive of the provider's own children and any children who reside in the home, when at least one child receives care for compensation. A family day home serving five through 12 children, exclusive of the provider's own children and any children who reside in the home, shall be licensed. A family day home caring for more than four children under the age of two years, including the provider's own children and any children who reside in the home, shall be licensed or voluntarily registered. A family day home where the children in care are all related to the provider by blood or marriage shall not be required to be licensed.

"Good character and reputation" means knowledgeable and objective people agree that the individual (i) maintains business, professional, family, and community relationships that are characterized by honesty, fairness, and truthfulness; and (ii) demonstrates a concern for the well-being of others to the extent that the individual is considered suitable to be entrusted with the care, guidance, and protection of children. Relatives by blood or marriage, and people who are not knowledgeable of the individual, such as recent acquaintances, shall not be considered objective references.

"High school program completion or the equivalent" means an individual has earned a high school diploma or General Education Development (G.E.D.) certificate, or has completed a program of home instruction equivalent to high school completion.

"Inaccessible" means not capable of being entered, reached, or used.

"Infant" means a child from birth up to 16 months of age.

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"Nighttime care" means care provided between 7 p.m. and 6 a.m.

"Parent" means the biological, foster or adoptive parent, legal guardian, or any individual with responsibility for, or custody of a child enrolled in or in the process of being enrolled in a family day home.

"Physician" means an individual licensed to practice medicine in any of the 50 states or the District of Columbia.

"Preschool" means children from two years up to the age of eligibility to attend public school, age five by September 30 of that same year.

"Programmatic experience" means time spent working directly with children in a group that is located away from the child's home. Work time shall be computed on the basis of full-time work experience during the period prescribed or equivalent work time over a longer period. Experience settings may include, but not be limited to, a child day program, family day home, child day center, boys and girls club, field placement, elementary school, or a faith-based organization.

"Provider" means an individual who is issued the family day home license by the Department of Social Services and who has primary responsibility in providing care, protection, supervision, and guidance of children in the family home.

"Relocation" means movement of occupants of the building to a safe location away from the vicinity of the building.

"Residence" means principal legal dwelling or abode that is occupied for living purposes by the provider and contains the facilities necessary for sleeping, eating, cooking, and family living.

"Sanitized" means treated in such a way as to remove bacteria and viruses from inanimate surfaces through first cleaning and secondly using a solution of one tablespoon of bleach mixed with one gallon of water and prepared fresh daily or using a sanitizing solution approved by the U.S. Environmental Protection Agency. The surface of the item is sprayed or dipped into the sanitizing solution and then allowed to air dry.

"School age" means eligible to attend public school, age five or older by September 30 of that same year.

"Serious injury" means a wound or other specific damage to the body such as, but not limited to, unconsciousness; broken bones; dislocation; deep cut requiring stitches; poisoning; concussion; and a foreign object lodged in eye, nose, ear, or other body orifice.

"Shelter-in-place" means movement of occupants of the building to designated protected spaces within the building.

"Substitute provider" means an individual who meets the qualifications of a provider; is designated by the provider; and who provides care, protection, supervision, and guidance for children in the family day home when the provider is absent from the home for more than two hours.

"Time out" means a discipline technique in which a child is moved for a brief time away from the stimulation and reinforcement of ongoing activities and other children in the group to allow the child who is losing self-control to regain composure.

"Toddler" means a child from 16 months of age up to 24 months of age.

VA.R. Doc. No. R17-4655; Filed August 18, 2016, 10:49 a.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **22VAC40-120. Minimum Standards for Licensed Family Day-Care Systems (amending 22VAC40-120-10).**

Statutory Authority: § 63.2-217 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Cynthia Carneal Heflin, Department of Social Services, Division of Licensing Programs, 801 East Main Street, 9th Floor, Richmond, VA 23219, telephone (804) 726-7140, FAX (804) 726-7132, TTY (800) 828-1120, or email cynthia.carneal@dss.virginia.gov.

Summary:

The amendment lowers the licensure threshold for family day homes to conform to Chapters 758 and 770 of the 2015 Acts of Assembly.

22VAC40-120-10. Introduction Definitions; license provisions.

A. ~~Legal Base.~~ Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia sets forth the responsibility of the Department of Social Services for licensure of family day-care systems, including the authority and responsibility of the State Board of Social Services for the development of regulations containing minimum standards and requirements.

It is a misdemeanor to operate a family day-care system without a license. (§ 63.2-1712 of the Code of Virginia)

B. Definitions. The following words and terms, when used in this chapter, shall have the following ~~meaning~~ meanings unless the context clearly indicates otherwise:

"Abused or neglected child" (see § 63.2-100 of the Code of Virginia) means any child younger than 18 years of age whose parents or other persons responsible for his or her care:

- a. Create or inflict, threaten to create or inflict, or allow to be created or inflicted a physical or mental injury by other than accidental means, or create a substantial risk of death,

disfigurement, or impairment of bodily or mental functions;

b. Neglect or refuse to provide care necessary for the child's health, unless the child is, in good faith, under treatment solely by spiritual means through prayer, according to the practice of a recognized church or denomination;

c. Abandon the child;

d. Commit or allow to be committed any sexual act upon a child in violation of the law.

"Child" means any person younger than 18 years of age.

"Commissioner" means the Commissioner of Social Services also known as the Director of the Virginia Department of Social Services. (§ 63.2-100 of the Code of Virginia)

"Complaint" means an accusation received either orally or in writing that:

a. A licensed family day-care system is not in compliance with one or more of these standards or one or more statutory requirements; or

b. A family day-care system home is not in compliance with one or more applicable requirements of these standards or one or more requirements as established by the family day-care system; or

c. A child or children in the care of a family day-care home, which is a member of a licensed family day-care system is or are being abused or neglected.

"Day-care" means care, protection, and guidance provided to a child or group of children separated from their parents or guardian for less than 24 hours per day at a location other than the home of the parents or guardian.

"Day-care provider" means an individual who, by contract with a family day-care system, provides day-care in his ~~or her~~ home.

"Department" means the Virginia Department of Social Services.

"Department representative" means an employee of the department, acting as the authorized agent of the commissioner in carrying out the responsibilities and duties specified in Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia.

"Director" means the licensee or a person designated by the licensee who oversees the day-to-day operation of the system, including compliance with all minimum standards for licensed family day-care systems.

"Family day-care system" means any person who approves family day-care homes as members of its system; who refers children to available day-care homes in that system; and who through contractual arrangement may provide central administrative functions, including, but not limited to, training of operators of family day-care homes; technical assistance and consultation to operators of family day-care

homes; inspection, supervision, monitoring, and evaluation of family day-care homes; and referral of children to available health and social services. (§ 63.2-100 of the Code of Virginia)

"Family day-care system home" means any private family home, which is an approved member of a family day-care system and receives nine or fewer children for care, protection, and guidance during any part of the 24-hour day except children who are related by blood or marriage to the person who maintains the home. Family day-care homes that are members of a licensed day-care system and are approved by that system to care for ~~six~~ five or more children are not subject to direct licensure by the department. (§ 63.2-100 of the Code of Virginia)

"Licensee" means any person, association, partnership, or corporation to whom the license is issued.

"Person" means any natural person or any association, partnership, or corporation. For the purpose of these standards public agencies are not included in this definition.

"Referral" means any activity by the family day-care system that provides assistance in locating or arranging day-care for children in homes that have been accepted or approved as members of the system, or in locating or arranging for health or social services from other sources based upon identified needs.

"Sponsor" means an individual, association, partnership, or corporation having the responsibility for planning and operating a family day-care system subject to licensure. The licensee is the sponsor of a family day-care system. (The sponsor may not, in all cases, be the owner of the physical plant including buildings or real estate, or both, in or on which the family day-care system office is located. In these instances the term "sponsor" as defined here and used in this chapter is considered to be the person, partnership, association, or corporation that owns the enterprise rather than the physical plant or real estate, or both.)

C. The license.

1. A license to operate a family day-care system is issued to a specific person, partnership, association, or corporation for an exact location, which will be indicated on the license.

2. The family day-care system shall be operated and conducted in the name of the sponsor or in such name as shall be designated on the application and as indicated on the license.

3. The license expires automatically and is not transferable when there is a change of sponsorship.

4. The current license shall be posted at all times at a place that is conspicuous to the public in the building housing the system office. If the system has more than one office, copies of the current license shall be posted in a place that is conspicuous to the public in each office.

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5. An annual license is one issued to a family day-care system when the activities, services, and facilities meet substantially the minimum standards and requirements for a license that are set forth in this chapter and any additional requirements that may be specified in Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia. The annual license is effective for 12 months unless it is sooner revoked or surrendered.

6. When an annual license expires, a provisional license may be issued for any period not to exceed six months if the applicant is temporarily unable to comply with all of the requirements; however, no facility may operate under any such provisional license and renewals of that license for a longer period than six successive months.

7. At the discretion of the commissioner, a conditional license may be issued to operate a new facility in order to permit the applicant to demonstrate compliance with all requirements. A conditional license and any renewal of that shall be for no longer a period than six successive months.

8. Terms of the license.

a. The terms of any license issued include:

- (1) The operating name of the family day-care system;
- (2) The name of the individual, the partnership, the association, or the corporation to whom the license is issued;
- (3) The physical location;
- (4) The number of homes that may be under contract to the system;
- (5) The period of time for which the license is effective; and
- (6) The total number of children who may be referred by the system and be receiving care at any given time in all homes that are members of the system.

b. The terms of the license may include other limitations that the commissioner may prescribe within the context of this chapter.

c. The provisional license cites the standards with which the licensee is not in compliance.

D. The licensing process.

1. Pre-application consultation. Upon request, the department's representative will provide consultation to any person seeking information about obtaining a license for a family day-care system. The purpose of such consultation is:

- a. To explain standards;
- b. To help the potential applicant to explore the operational demands of a licensed family day-care system;
- c. To provide assistance in locating sources of information and technical assistance;

- d. To alert the potential applicant of the need to determine whether local ordinances will affect the proposed operation (e.g. zoning, business license, etc.);
- e. To provide an on-site visit to a proposed family day-care system office, upon request.

2. The application.

a. The application for a license to operate a family day-care system shall be obtained from the department.

b. The application, together with all required information, shall be submitted to the department at least two months in advance of the planned opening date.

This is required in order that a determination of compliance with the provisions of Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia and with the Standards for Licensed Family Day-Care Systems as set forth in this chapter may be made.

Among other things, the information submitted shall be sufficient to enable the department's representative to determine, during the subsequent investigation, the specific services to be offered, the adequacy of staff to provide these services, the financial capability of the applicant, the character and reputation of the applicant, including the officers and agents of any association, partnership, or corporation as mandated by § 63.2-1702 of the Code of Virginia.

c. The application shall be signed by the individual responsible for the operation of the family day-care system. The application for a family day-care system to be operated by a board shall be signed by an officer of the board, preferably the chairman.

3. The investigation.

a. Following receipt of the application, the department's representative will make an on-site inspection of the proposed office and an investigation of the proposed services, as well as an investigation of the character and reputation of the applicant, and, upon receipt of the initial application, an investigation of the applicant's financial responsibility.

b. Applicants for licensure and licensees shall at all times afford the commissioner reasonable opportunity to inspect all of their facilities, books, and records, and to interview their agents and employees and any person living or participating in such facilities, or under their custody, control, direction, or supervision. (§ 63.2-1706 of the Code of Virginia) The financial records of an initial applicant shall not be subject to inspection if the applicant submits an operating budget and at least one credit reference.

4. Notice to the applicant of commissioner's action. Upon completion of the investigation of the application for a license, the applicant will be notified in writing of the commissioner's decision.

If the license is issued, an accompanying letter will cite any areas of noncompliance with standards. This letter will also include any limitations on the license and may contain recommendations.

If a license is to be denied, the letter will state the reasons for the intent to deny and will set forth the applicant's right to an administrative hearing.

5. Procedures for renewal of annual, provisional, or conditional license. In order to renew an annual, provisional, or conditional license, the licensee must complete the renewal application and return it, together with any required attachments, to the department. In order to assure timely processing, the renewal application should be completed and returned within 10 days after it is received from the department.

The procedure for investigation and issuance or denial of the license as set forth in subdivisions 3 and 4 of this subsection will be followed.

6. Early compliance (replacement of a provisional or conditional license with an annual license).

a. A provisional or conditional license may be voided and an annual license issued when all of the following conditions exist:

(1) The facility complies with all standards listed on the face of the provisional or conditional license well in advance of the expiration date of the provisional or conditional license, and no additional areas of noncompliance exist;

(2) Compliance has been verified by an on-site observation by the department representative or by written evidence provided by the licensee; and

(3) All other terms of the license remain the same.

b. A request to void a provisional or conditional license and to issue an annual license must be made in writing by the licensee to the regional office of the department from which the family day-care system's license to operate was issued.

c. If the request is approved by the department, the effective date of the new annual license will be the same as the beginning date of the provisional or conditional license.

7. Situation requiring a new application. A new application must be filed when sponsorship of the family day-care system changes.

8. Modification.

a. The conditions of the license may be modified during the effective dates of the license with respect to increasing or decreasing the number of homes that may be placed under contract, the number of children who may be referred by the system and be receiving care at a given time, changing the name of the system when there is no change in sponsorship, changing location of the

system office, or other conditions caused by changes in staff, program, or facilities.

b. The licensee shall report to the department any contemplated changes in operation that would affect either the terms of the license or the continuing eligibility for a license. (This does not mean the department has to approve changes in staff or program unless they affect the terms of the license or continuing eligibility.)

c. This information shall be submitted in writing by the licensee to the regional office of the department from which the system's license to operate was issued.

d. The department will then determine whether such changes may be approved and the license modified accordingly or whether a new application must be filed.

9. Determination of continued compliance. In order to determine continued compliance with standards during the effective dates of the license, the department's representative will make announced and unannounced visits to the office or offices of the system and may make such visits to homes that are members of the system.

10. Complaint investigation.

a. The department has the responsibility to investigate any complaints regarding alleged violations of minimum standards for licensed family day-care systems and provisions of Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia.

b. The licensee has the responsibility to investigate any complaints regarding any family day-care home that is approved as a member of its system. (See 22VAC40-120-50 C.) At its discretion the department may also investigate complaints against individual homes.

11. Revocation. Any license may be revoked for failure to maintain these standards or for violation of the provisions of Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia.

12. Appeals. The applicant or licensee has the right to request an administrative hearing regarding any denial or revocation of a license, in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

Following the receipt of the final order that transmits the department's decision after the administrative hearing, the applicant/licensee has the right to appeal to a court of record in accordance with § 63.2-1710 of the Code of Virginia.

VA.R. Doc. No. R17-4740; Filed August 18, 2016, 10:50 a.m.

Final Regulation

<p>REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the</p>
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appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 22VAC40-180. **Voluntary Registration of Family Day Homes - Requirements for Providers (amending 22VAC40-180-10 through 22VAC40-180-40, 22VAC40-180-60, 22VAC40-180-80, 22VAC40-180-90, 22VAC40-180-110).**

Statutory Authority: §§ 63.2-217 and 63.2-1704 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Cynthia Carneal Heflin, Division of Licensing Programs, Department of Social Services, 801 East Main Street, 9th Floor, Richmond, VA 23219, telephone (804) 726-7140, FAX (804) 726-7132, TTY (800) 828-1120, or email cynthia.carneal@dss.virginia.gov.

Summary:

Amendments conform the regulation to changes to §§ 63.2-100 and 63.2-1704 of the Code of Virginia enacted by Chapters 758 and 770 of the 2015 Acts of Assembly that reduced the capacity of a voluntarily registered family day home from five children to four children, exclusive of the provider's own children and any children who reside in the home, and include changes to definitions and capacity references.

Part I
Introduction

22VAC40-180-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Adult" means any individual 18 years of age or older.

"Age appropriate" means suitable to the chronological age range and developmental characteristics of a specific group of children.

"Age groups" means the following:

"Infant" means children from birth to 16 months.

"Toddler" means children from 16 months to 31 months.

"Preschooler" means children from 31 months up to the age of eligibility to be enrolled in kindergarten or an equivalent program.

"School age" means children who are eligible to be enrolled in kindergarten or attend public school.

"Age of eligibility to attend public school" means five years of age or older by September 30.

"Care, protection and guidance" means responsibility assumed by a family day home provider for children receiving care in the home, whether they are related or unrelated to the provider.

"Certificate of registration" means a document issued by the commissioner to a family day provider, acknowledging that the provider has been certified by the contracting organization or the department and has met the Requirements for Voluntary Registration of Family Day Homes - Requirements for Providers. (22VAC40-180-10 ~~et seq.~~).

"Child" means any individual under 18 years of age.

"Commissioner" means the Commissioner of Social Services.

"Commissioner's designee" means a designated individual who or a division within the Department of Social Services that is delegated to act on the commissioner's behalf in one or more specific responsibilities.

"Contracting organization" means the agency which has contracted with the Department of Social Services to administer the voluntary registration program for family day homes.

"Denial of a certificate of registration" means a refusal by the commissioner to issue an initial certificate of registration.

"Department" means the Virginia Department of Social Services.

"Department's representative" means an employee or designee of the Virginia Department of Social Services acting as the authorized agent of the commissioner ~~in carrying out the responsibilities and duties specified in Chapter 10 (§ 63.1-195 et seq.) of Title 63.1 of the Code of Virginia.~~

"Evaluate" or "evaluation" means the review of a family day provider by a contracting organization upon receipt of an application for a certificate of registration to verify that the applicant meets the Requirements for Providers.

"Family day home" means a child day program offered in the residence of the provider or the home of any of the children in care for one through 12 children under the age of 13, exclusive of the provider's own children and any children who reside in the home, when at least one child receives care for compensation. ~~From July 1, 1993, until July 1, 1996, A family day homes home serving nine five through 12 children, exclusive of the provider's own children and any children who reside in the home, shall be licensed. Effective July 1, 1996, family day home serving six through 12 children, exclusive of the provider's own children and any children who reside in the home, shall be licensed. However, no A family day home shall care caring for more than four children under the age of two, including the provider's own children and any children who reside in the home, unless the family day home is shall be licensed or voluntarily registered. However, a A family day home where the children in care are all grandchildren of related to the provider by blood or marriage shall not be required to be licensed.~~

"Family day provider applicant" or "provider applicant" means a person 18 years of age or older who has applied for a certificate of registration.

"Monitor" or "monitoring visit" means to visit a registered family day provider and to review the provider's compliance with the applicable requirements described in the Requirements for Providers.

"Parent" means a biological, foster or adoptive parent, legal guardian, or any person with responsibility for, or custody of, a child enrolled or in the process of being enrolled in a family day home.

"Physician" means a person licensed to practice medicine.

"Provider" or "registered family day provider" means a person who has received an initial or renewed certificate of registration issued by the commissioner. This provider has primary responsibility for providing care, protection, supervision, and guidance to the children in the registered home.

"Provider assistant" means a person 14 years of age or older who has been designated by the family day provider and approved by the contracting organization to assist the provider in the care, protection, supervision, and guidance of children in the home.

"Refusal to renew a certificate of registration" means the nonissuance of a certificate of registration by the commissioner after the expiration of the existing certificate of registration.

"Registration fee" means the payment to a contracting organization by a provider or applicant upon filing an application for a certificate of registration.

"Registered family day home" means any family day home which has met the standards for voluntary registration for such homes pursuant to regulations promulgated by the State Board of Social Services and which has obtained a certificate of registration from the commissioner.

"Renewal of a certificate of registration" means the issuance of a certificate of registration by the commissioner after the expiration of the existing certificate of registration.

"Requirements for Providers" means the procedures and general information set forth for providers operating family day homes who voluntarily register. This includes staffing requirements and a self-administered health and safety checklist.

"Revocation of a certificate of registration" means the removal of a provider's current certificate of registration by the commissioner for failure to comply with the applicable Requirements for Providers.

"Substitute provider" means a provider who meets the Requirements for Providers and who is readily available to provide substitute child care in a registered provider's home or in the substitute provider's home.

"USDA" means ~~United States~~ U.S. Department of Agriculture.

22VAC40-180-20. Legal authority. (Repealed.)

~~Section 63.1-196.04 of the Code of Virginia was amended and reenacted in the 1993 General Assembly session to establish provisions for the voluntary registration of family day homes.~~

Part II

Provider Registration and General Procedures

22VAC40-180-30. Provider eligibility.

A. A family day provider and substitute provider shall be 18 years of age or older.

B. A family day assistant shall be 14 years of age or older.

C. A family day provider, assistant or assistants and substitute provider shall be able to read, write, understand and carry out the responsibilities in the Requirements for Providers.

D. A family day provider and substitute provider shall live in a county, city, or town that does not have a local ordinance for the regulation or licensure of family day homes.

E. A family day provider that is voluntarily registered pursuant to § 63.2-1704 of the Code of Virginia shall not be required by law to be licensed. Family day homes serving five through 12 children younger than the age of 13 years, exclusive of the provider's own children and any children who reside in the home, shall be licensed.

22VAC40-180-40. Application for registration.

A. A family day provider applicant for a certificate of registration shall submit to the contracting organization a completed application form, which shall include, but not be limited to:

1. The health and safety checklist and statements of assurance as noted in Part III (22VAC40-180-120 et seq.);
2. A tuberculosis test report as noted in subsection C of this section;
3. A criminal records check and Child Protective Services Central Registry Clearance as indicated in subsection D of this section;
4. A sworn disclosure statement as noted in subsection D of this section; and
5. General information as noted in subsection B of this section.

B. The provider shall also indicate a preference as to whether:

1. The provider applicant is interested in participating in the USDA food program (if the registrant is not currently participating);
2. The provider applicant is willing and able to serve as a substitute provider (after the primary provider obtains consent from parents of enrolled children) and is interested in being included on the substitute provider list maintained by the contracting organization.

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C. Health information shall be submitted on the family day provider applicant, assistant or assistants and substitute providers, if any, and any other adult household member who comes in contact with children or handles food served to children. The applicant shall return the completed application form along with a tuberculosis (TB) form which provides written proof of the results of a tuberculosis examination for the applicant, the provider assistant, if any, and all other persons who care for children in the family day home as follows:

1. Initial tuberculosis examination and report.

- a. Within 90 days before the date of initial application for registration or within 30 days before employment or having contact with children in a registered home, each individual shall obtain a tuberculin skin test indicating the absence of tuberculosis in a communicable form;
- b. Each individual shall submit a statement that he is free of tuberculosis in a communicable form, including the results of the test;
- c. The statement shall be signed by a physician, the physician's designee, or an official of a local health department; and
- d. The statement shall be filed in the individual's record maintained at the family day home.

EXCEPTION: An individual may delay obtaining the tuberculosis test if a statement from a physician is provided that indicates the test is not advisable for specific health reasons. This statement shall include an estimated date for when the test can be safely administered. The individual shall obtain the test no later than 30 days after this date.

2. Subsequent evaluations.

- a. An individual who had a significant (positive) reaction to a tuberculin skin test and whose physician certifies the absence of communicable tuberculosis shall obtain chest x-rays on an annual basis for the following two years.
 - (1) The individual shall submit statements documenting the chest x-rays and certifying freedom from tuberculosis in a communicable form;
 - (2) The statements shall be signed by a licensed physician, the physician's designee, or an official of a local health department;
 - (3) The statements shall be filed in the individual's record maintained at the family day home; and
 - (4) Following the two-year period during which chest x-rays are required annually, additional screening shall be obtained every two years.
- b. An individual who had a nonsignificant (negative) reaction to an initial tuberculin skin test shall obtain additional screening every two years thereafter.
- c. Any individual who comes in contact with a known case of tuberculosis or who develops chronic respiratory

symptoms shall, within 30 days of exposure or development, receive an evaluation in accordance with subdivision C 1 of this section.

3. At the request of the contracting organization or the Department of Social Services, a report of examination by a physician shall be obtained when there is an indication that the safety of children in care may be jeopardized by the physical or mental health of a specific individual.

D. Information certifying that those in contact with children do not have a criminal background shall be submitted. Attachments will include:

1. A criminal records check, as specified in ~~§ 63.1-198.1~~ §§ 63.2-1720 and 63.2-1721 of the Code of Virginia, conducted no more than 90 days before the date of initial application and no more than 90 days before the date of application for renewal, for the provider applicant, the provider assistant, and the substitute provider, if any, and any adults residing in the home;
2. A Child Protective Services (CPS) Central Registry Clearance conducted no more than 90 days before the date of initial application and no more than 90 days before the date of application for renewal, for the provider applicant, the provider assistant, and the substitute provider, if any, and any adults residing in the home; and
3. A sworn disclosure statement for the provider applicant, the provider assistant, and the substitute provider, if any, and any adults residing in the home.

22VAC40-180-60. Issuance of a certificate of registration.

A. After the provider applicant has satisfactorily met the requirements for voluntary registration, the contracting organization shall certify the provider applicant as eligible for registration to the commissioner and recommend the issuance of a certificate of registration.

B. The commissioner shall issue the certificate of registration, which shall not be transferable, to a specific provider at a specific location.

C. If it is necessary to change any identifying information (name and phone) noted on the certificate of registration prior to the end of the two-year registration period, the provider shall advise the contracting organization no later than 14 calendar days after the change.

D. If the provider changes location prior to the end of the two-year registration period, the provider shall permit and participate in a second home visit and an evaluation of the new residence within 30 days of occupying the residence.

E. The provider shall not claim in advertising or in any written or verbal announcement to be registered with the Commonwealth of Virginia unless a certificate of registration is currently in effect.

F. A provider who has been denied a certificate of registration or who has had a certificate of registration revoked or refused renewal by the commissioner shall not be

eligible for issuance of a certificate of registration until six months after the date of such action, unless the waiting period is waived by the commissioner as noted in Chapter 10 (§ 63.1-195 et seq.) of Title 63.1 of the Code of Virginia.

22VAC40-180-80. Denials, revocations, refusals to renew and provider appeals procedures.

A. A provider's certificate of registration may be denied, revoked, or refused renewal by the commissioner for cause including, but not limited to:

1. Failure to comply with adult-child ratios, staffing requirements, or other standards set forth in the Requirements for Providers;
2. Use of fraud in obtaining a certificate of registration or in the subsequent operations of the family day home;
3. Any conduct or activity which adversely affects or presents a serious hazard to the health, safety, and general well-being of an enrolled child, or which otherwise demonstrates unfitness by a provider to operate a family day care home;
4. Refusal to furnish the contracting organization or the department with records;
5. Refusal to permit immediate admission to the family day home to the parent of an enrolled child who is present in the home or to an authorized representative of the contracting organization or department when any enrolled child is present; or
6. Documentation maintained by a contracting organization or the department that a certificate of registration has been denied, revoked, or refused renewal by the commissioner to the provider during the six months prior to the date an application is resubmitted for a certificate of registration.

B. When a provider is found to be in violation of any of the provisions of subsection A of this section, the contracting organization shall notify the provider of the violation or violations first orally and then in writing, and, when appropriate, shall afford the provider an opportunity to abate the violation or violations within a ~~time frame~~ timeframe agreed upon by the contracting organization and the provider. The provider shall immediately abate the violation or violations in situations where children are at risk of abuse or neglect or serious harm or injury.

C. If the provider fails to abate the violation or violations within the agreed upon ~~time frame~~ timeframe or commits a subsequent violation, the contracting organization may recommend to the commissioner that the certificate of registration be denied, revoked, or refused renewal. A statement referencing the standard or standards violated shall be included with the recommendation.

D. Upon notification of the contracting organization's intent to recommend that a certificate of registration be denied, revoked, or refused renewal, a provider may request a review in writing by the contracting organization's review committee within 15 calendar days after receipt of notification.

E. The contracting organization shall submit its recommendation of the provider's eligibility for issuance of a certificate of registration to the commissioner's designee. If a certificate of registration is denied, revoked or refused renewal by the commissioner's designee, the provider may appeal the decision in accordance with the Administrative Process Act (§ ~~9-6.14:1 et seq.~~ 2.2-4000 et seq. of the Code of Virginia) and may request a hearing in writing within 15 calendar days after receipt of notification of the decision.

F. After the hearing, the commissioner shall issue the final order, which may be appealed in accordance with the Administrative Process Act.

G. A provider whose certificate of registration is revoked or refused renewal shall notify the parent or parents of each child enrolled within 10 calendar days after receipt of notification of such action.

22VAC40-180-90. Provider reporting requirements.

A. The provider shall verbally notify the local department of social services or call the toll free number for the Child Protective Services Unit (~~1-800-552-7096/TDD~~) (1-800-552-7096) immediately whenever there is reason to suspect that a child has been or is being subjected to any kind of child abuse or neglect by any person.

B. The provider shall report the following incidents to the contracting organization as soon as possible but no later than the beginning of the contracting organization's next working day:

1. A lost or missing child when it was necessary to seek assistance from local emergency or police personnel;
2. Any injury that occurs while in the provider's care that results in the admission of a child to a hospital;
3. The death of a child while in the provider's care;
4. Any damage to the provider's home that affects the provider's compliance with the Requirements for Providers;
5. Any occurrence of a reportable disease, as specified in the list of reportable diseases provided by the contracting organization;
6. The termination of all family day care services by the provider; or
7. The provider's decision to surrender the certificate of registration in accordance with the Requirements of the Voluntary Registration Program.

22VAC40-180-110. Staffing requirements.

A. The provider shall ensure that the total number of children receiving care at any one time does not exceed four, which is the maximum capacity allowed by law (§ ~~63.1-196.04~~ 63.2-1704 of the Code of Virginia) for family day homes that may apply for voluntary registration.

B. The following adult-to-child ratios shall be maintained for children receiving care until October 31, 1993. (NOTE: The adult-to-child ratios for voluntary registration shall be

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same as those for licensed day homes effective November 1, 1993.)

1. One adult may care for nine children at any one time, within the limitations that follow. This includes provider by blood or marriage the provider's own children and any children who reside in the home.
 - a. Of the nine children, no more than six shall be under school age without an assistant;
 - b. Of the children under school age, no more than five shall be under 31 months (2 ½ years of age or younger) even when an assistant is present;
 - c. Of the children under 31 months, no more than three shall be under 16 months without an assistant.
2. School age children who are 10 years of age and older shall not count in determining the ratio of adults to children for staffing purposes.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (22VAC40-180)

~~Voluntary Registration Health and Safety Checklist (rev. 8/00).~~

~~Voluntary Registration Provider Application Form, 032-05-210/2-A (rev. 6/04).~~

~~Voluntary Registration Provider Application Form, 032-05-210/2-B (eff. 6/04).~~

[Voluntary Registration Health and Safety Checklist, 032-05-0048-02-eng \(rev. 6/2016\)](#)

[Voluntary Registration Provider Application Form, 032-05-0210-05-eng \(rev. 6/2016\)](#)

VA.R. Doc. No. R17-4656; Filed August 18, 2016, 10:50 a.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **22VAC40-185. Standards for Licensed Child Day Centers (amending 22VAC40-185-40).**

Statutory Authority: §§ 63.2-217 and 63.2-1734 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Tatanishia Armstrong, Licensing Consultant, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7152 ext. 7, FAX (804) 726-7132, or email tatanishia.armstrong@dss.virginia.gov.

Summary:

The amendments implement the provisions of Chapter 580 of the 2016 Acts of Assembly, which amended the definition of offense in § 63.2-1719 of the Code of Virginia to include a conviction of any offense set forth in § 9.1-902 that results in the person's requirement to register in the Sex Offender and Crimes Against Minors Registry. Also an amendment adds a reference to subsection C of § 63.2-1720, which describes a barrier crimes exception for child day centers.

22VAC40-185-40. Operational responsibilities.

A. Applications for licensure shall conform with Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2 of the Code of Virginia and the regulation entitled General Procedures and Information for Licensure, 22VAC40-80.

B. Pursuant to §§ § 63.2-1719, subsection C of § 63.2-1720, and § 63.2-1721 of the Code of Virginia and the regulation entitled Background Checks for Child Welfare Agencies, 22VAC40-191, the applicant and any agent at the time of application who is or will be involved in the day-to-day operations of the center, or who is or will be alone with, in control of, or supervising one or more of the children, shall be of good character and reputation and shall not be guilty of an offense. ~~Offenses are barrier crimes, conviction of any other felony not included in the definition of barrier crime unless five years have elapsed since conviction, and a founded complaint of child abuse or neglect as defined in § 63.2-1719 of the Code of Virginia.~~

C. The sponsor shall afford the commissioner or his agents the right at all reasonable times to inspect facilities and to interview his agents, employees, and any child or other person within his custody or control, provided that no private interviews may be conducted with any child without prior notice to the parent of such child.

D. The license shall be posted in a place conspicuous to the public (§ 63.2-1701 of the Code of Virginia).

E. The operational responsibilities of the licensee shall include, but not be limited to, ensuring that the center's activities, services, and facilities are maintained in compliance with these standards, the center's own policies and procedures that are required by these standards, and the terms of the current license issued by the department.

F. Every center shall ensure that any advertising is not misleading or deceptive as required by § 63.2-1713 of the Code of Virginia.

G. The center shall meet the proof of child identity and age requirements as stated in § 63.2-1809 of the Code of Virginia.

H. The sponsor shall maintain public liability insurance for bodily injury for each center site with a minimum limit of at least \$500,000 each occurrence and with a minimum limit of \$500,000 aggregate.

1. A public sponsor may have equivalent self-insurance that is in compliance with the Code of Virginia.
2. Evidence of insurance coverage shall be made available to the department's representative upon request.

I. The center shall develop written procedures for injury prevention.

J. Injury prevention procedures shall be updated at least annually based on documentation of injuries and a review of the activities and services.

K. The center shall develop written playground safety procedures which shall include:

1. Provision for active supervision by staff to include positioning of staff in strategic locations, scanning play activities, and circulating among children; and
2. Method of maintaining resilient surface.

L. Hospital-operated centers may temporarily exceed their licensed capacity during a natural disaster or other catastrophe or emergency situation and shall develop a written plan for emergency operations, for submission to and approval by the Department of Social Services.

M. When children 13 years or older are enrolled in the program and receive supervision in the licensed program, they shall be counted in the number of children receiving care and the center shall comply with the standards for these children.

V.A.R. Doc. No. R17-4754; Filed August 18, 2016, 10:51 a.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: 22VAC40-191. **Background Checks for Child Welfare Agencies (amending 22VAC40-191-10, 22VAC40-191-50).**

Statutory Authority: §§ 63.2-217 and 63.2-901.1 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Cynthia Carneal Heflin, Division of Licensing Programs, Department of Social Services, 801 East Main Street, 9th Floor, Richmond, VA 23219, telephone

(804) 726-7140, FAX (804) 726-7132, TTY (800) 828-1120, or email cynthia.carneal@dss.virginia.gov.

Summary:

Pursuant to Chapters 758 and 770 of the 2015 Acts of Assembly and Chapter 580 of the 2016 Acts of Assembly, the amendments (i) change the definition of "family day home" to reflect amendments to § 63.2-100 of the Code of Virginia lowering the threshold required for licensure to providers caring for five children at any one time, exclusive of the provider's own children and any children residing in the home, and clarify that providers who only care for children related to them by blood or marriage are not required to be licensed; (ii) change the definition of "offense" to reflect amendments to § 63.2-1719 of the Code of Virginia to include a conviction of any offense that results in the person's requirement to register in the Sex Offender and Crimes Against Minors Registry, which was added to the list of crimes and prohibitions that constitute a barrier to licensure or registration as a child welfare agency, approval as a foster or adoptive parent by a child-placing agency, approval as a family day home by a family day system, or employment or serving as a volunteer at a child welfare agency; and (iii) make technical edits to reflect these changes.

22VAC40-191-10. Defining words and phrases.

The following words and terms when used in this regulation shall have the following meanings unless the context clearly indicates otherwise:

"Agent" means a person who is empowered to act on behalf of the applicant that is an association, partnership, limited liability company, business trust, public agency, or corporation in matters relating to a child welfare agency.

"Applicant" means the person or persons applying for approval as a (i) licensed family day home; (ii) licensed family day system; (iii) licensed child-placing agency; (iv) licensed independent foster home; (v) voluntarily registered family day home; (vi) family day home approved by a licensed family day system; (vii) foster and adoptive home approved by a licensed child-placing agency; (viii) religious exempt child day center or (ix) licensed child day center. In the case of a sole proprietorship, the applicant is the individual owner. In the case of a partnership, the applicants are all the partners. If the applicant is a corporation, association, or business trust, the applicants are officers. If the applicant is a limited liability company, the applicants are the members or managers. If the applicant is a public agency, the applicant is the person responsible for the overall operation of the public agency.

"Approved" means having obtained the status of approval through the process required in Minimum Standards for Licensed Family Day-Care Systems (22VAC40-120) or Standards for Licensed Child-Placing Agencies (22VAC40-131). Approved facilities are family day homes approved by licensed family day systems. Approved foster and adoptive

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parents include resource, foster, adoptive, treatment foster, and short-term foster parents and families approved by child-placing agencies.

"Background checks" means a sworn statement or affirmation, a criminal history record report, and a child protective services central registry check.

"Barrier crime" means a conviction identified at § 63.2-1719 in the Code of Virginia. The convictions, and Code of Virginia references, are: a felony violation of a protective order as set out in § 16.1-253.2, murder or manslaughter as set out in Article 1 (§ 18.2-30 et seq.), malicious wounding by mob as set out in § 18.2-41, abduction as set out in subsection A or B of § 18.2-47, abduction for immoral purposes as set out in § 18.2-48, assault and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.), robbery as set out in § 18.2-58, carjacking as set out in § 18.2-58.1, extortion by threat as set out in § 18.2-59, felony stalking as set out in § 18.2-60.3, a felony violation of a protective order as set out in § 18.2-60.4, sexual assault as set out in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2, arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2, burglary as set out in Article 2 (§ 18.2-89 et seq.) of Chapter 5 of Title 18.2, any felony violation relating to possession or distribution of drugs as set out in Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2, drive-by shooting as set out in § 18.2-286.1, use of a machine gun in a crime of violence as set out in § 18.2-289, aggressive use of a machine gun as set out in § 18.2-290, use of a sawed-off shotgun in a crime of violence as set out in subsection A of § 18.2-300, failure to secure medical attention for an injured child as set out in § 18.2-314, pandering as set out in § 18.2-355, crimes against nature involving children as set out in § 18.2-361, incest as set out in § 18.2-366, taking indecent liberties with children as set out in § 18.2-370 or § 18.2-370.1, abuse and neglect of children as set out in § 18.2-371.1, obscenity offenses as set out in § 18.2-374.1, possession of child pornography as set out in § 18.2-374.1:1, electronic facilitation of pornography as set out in § 18.2-374.3, abuse and neglect of incapacitated adults as set out in § 18.2-369, employing or permitting a minor to assist in an act constituting an offense under Article 5 (§ 18.2-372 et seq.) of Chapter 8 of Title 18.2 as set out in § 18.2-379, delivery of drugs to prisoners as set out in § 18.2-474.1, escape from jail as set out in § 18.2-477, felonies by prisoners as set out in § 53.1-203; or an equivalent offense in another state.

"Board" means State Board of Social Services.

"Central registry" means the record of founded complaints of child abuse and neglect maintained by the Department of Social Services.

"Central registry finding" means the record of founded complaints of child abuse and neglect for an individual.

"Central Criminal Records Exchange" or "CCRE" means the information system containing conviction data of crimes

committed in Virginia. The system is maintained by the Department of State Police.

"Child day program" means a regularly operating service arrangement for children where, during the absence of a parent or guardian, a person or organization has agreed to assume responsibility for the supervision, protection, and well-being of a child under the age of 13 for less than a 24-hour period.

"Child-placing agency" means any person or agency licensed to place children in foster homes, adoptive homes or independent living arrangements pursuant to § 63.2-1819 of the Code of Virginia or a local board that places children in foster homes or adoptive homes pursuant to §§ 63.2-900, 63.2-903 and 63.2-1221 of the Code of Virginia. Officers, employees, or agents of the Commonwealth, or any locality acting within the scope of its authority as such, who serve as or maintain a child-placing agency, are not required to be licensed.

"Child welfare agency" means a child day center, child-placing agency, children's residential facility, family day home, family day system, or independent foster home. For purposes of this ~~regulation~~ chapter, the requirements for child welfare agencies also apply to foster or adoptive homes requesting approval or with approval by child-placing agencies and family day homes requesting approval or with approval by family day systems.

"Commissioner" means the Commissioner of the ~~Virginia~~ Department of Social Services or his designee.

"Contract agency" means an entity with which the facility or a parent has an agreement to provide services to a child or children while attending the facility.

"Contract employee" means a person with whom the facility or a parent has an agreement to provide services to a child or children while attending the facility.

"Contracting organization" means an agency that has been designated by the Department of Social Services to administer the voluntary registration program for family day homes.

"Criminal history record check" means the process the Department of State Police uses to generate a criminal record report on a person. The check may be a state check generated solely through the Central Criminal Records Exchange or a check forwarded through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining national criminal history record information.

"Criminal history record report" means either the criminal record clearance or the criminal history record issued by the Central Criminal Records Exchange, Department of State Police. The report identifies convictions within the Commonwealth.

"Department" means the Department of Social Services.

"Department representative" means an employee of the department who carries out regulatory duties or an agency acting as an authorized agent of the department carrying out approval functions. Licensed family day systems have authority to approve family day homes. Licensed child-placing agencies have authority to approve foster and adoptive parents.

"Disqualifying background" means ~~(i) having been the subject of a founded complaint of child abuse or neglect even if his record has been purged from the Child Abuse and Neglect Central Registry system, (ii) a barrier crime conviction, or (iii) any other felony not included in the definition of "barrier crime," unless five years have elapsed since the conviction~~ an offense, as defined in § 63.2-1719 of the Code of Virginia. For the purpose of this regulation chapter, having been the subject of a founded abuse or neglect complaint as described in "offense" includes records that have been purged from the child abuse and neglect central registry. However, no person is considered to be the subject of a founded complaint of child abuse or neglect until a decision upholding the finding has been rendered by the hearing officer after the administrative hearing, provided the person complies with the requirements for requesting an administrative hearing. No person is considered to be the subject of a founded complaint of child abuse or neglect if the child abuse or neglect finding is overturned by an administrative hearing or a subsequent court decision.

"Employee" means a person hired by a facility or with whom the facility has an employment agreement. A provider assistant in a family day home is considered an employee in this chapter.

"Facility" means (i) a licensed family day home; (ii) a licensed family day system; (iii) a licensed child-placing agency; (iv) a licensed independent foster home; (v) a voluntarily registered family day home; (vi) a family day home approved by a licensed family day system; (vii) a licensed child day center; (viii) a religious exempt child day center; and (ix) an applicant seeking a waiver in order to establish one of the above listed entities.

"Family day home" means a child day program offered in the residence of the provider or the home of any of the children in care for one through 12 children under the age of 13 years, exclusive of the provider's own children and any children who reside in the home, when at least one child receives care for compensation. The provider of a licensed or registered family day home must disclose to the parents or guardians of children in ~~their~~ his care the percentage of time per week that persons other than the provider will care for the children. Family day homes serving ~~six~~ five through 12 children, exclusive of the provider's own children and any children who reside in the home, must be licensed. ~~However,~~ No family day home shall care for more than four children under the age of two years, including the provider's own children and any children who reside in the home, unless the

family day home is licensed or voluntarily registered. However, a family day home where the children in care are all ~~grandchildren of the provider related to the provider by blood or marriage~~ is not required to be licensed.

"Family day system" means any person ~~who~~ that approves family day homes as members of its system; ~~who that~~ refers children to available family day homes in that system; and ~~who that~~, through contractual arrangement, may provide central administrative functions including, but not limited to, training of operators of member homes; technical assistance and consultation to operators of member homes; inspection, supervision, monitoring, and evaluation of member homes; and referral of children to available health and social services.

"Good character and reputation" means that the person (i) maintains business, professional, family, and community relationships that are characterized by honesty, fairness, truthfulness and dependability and (ii) has a history or pattern of behavior that demonstrates that the person is suitable and able to care for, guide, supervise, and protect children.

"Independent foster home" means a private family home in which any child, other than a child by birth or adoption of such person, resides as a member of the household and has been placed there independently of a child-placing agency except (i) a home ~~in which are received~~ that receives only children related by birth or adoption of the person who maintains such home and children of personal friends of such person and (ii) a home that receives a child or children committed under the provisions of subdivision A 4 of § 16.1-278.2, subdivision 6 of § 16.1-278.4, or subdivision A 13 of § 16.1-278.8 of the Code of Virginia.

"Involved in the day-to-day operations" means:

1. In a supervisory or management position, making daily decisions regarding the operation of the facility;
2. Counted by the facility for purposes of staff-to-children ratios;
3. Providing casework services for a child-placing agency;
4. Employed by a licensed family day system as a home visitor; or
5. Having access to child-related and client-related records or to facility personnel records.

"Licensed" means having met the requirements of and obtained licensure as a licensed family day-care system, licensed independent foster home, licensed private child-placing agency, or licensed family day home.

"Living in" means to reside in a place for an extended or permanent period of time.

"Local agency" means local department of social services.

"May" means has permission.

"Must" means the action is a requirement.

"Must not" means the action is prohibited.

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"National criminal background check" means criminal history record information from the Federal Bureau of Investigation.

"Offense" means a (i) conviction of a barrier crime, (ii) conviction of any other felony not included in the definition of barrier crime unless five years have elapsed since conviction, ~~or~~ (iii) founded complaint of child abuse or neglect within or outside the Commonwealth, or (iv) a conviction of an offense set forth in § 9.1-902 of the Code of Virginia or a finding that a person is not guilty by reason of insanity in accordance with Chapter 11.1 (§ 19.2-182.2 et seq.) of Title 19.2 of the Code of Virginia of an offense set forth in § 9.1-902 that results in the person's requirement to register with the Sex Offender and Crimes Against Minors Registry pursuant to § 9.1-901 of the Code of Virginia, or any similar registry in any other state. Convictions include prior adult convictions and juvenile convictions or adjudications of delinquency based on a crime that would be a felony if committed by an adult within or outside the Commonwealth.

"Other felony" means conviction for any felony in the last five years that is not a barrier crime felony.

"Parent-volunteer" means someone supervising, without pay, a group of children that includes the parent-volunteer's own child in a program that operates no more than four hours per day, provided that the parent-volunteer works under the direct supervision of a person who has received a clearance pursuant to § 63.2-1720 or § 63.2-1724 of the Code of Virginia.

"Registered" means having obtained the status of registration through the process required in Voluntary Registration of Family Day Homes - Requirements for Providers (22VAC40-180).

"Registered family day home" means any family day home that has met the standards for voluntary registration for such homes ~~pursuant to regulations adopted by the board~~ and ~~that has~~ obtained a certificate of registration from the commissioner.

"Religious exempt center" means an unlicensed child day center operated or conducted under the auspices of a religious institution that has filed with the commissioner a satisfactory annual statement of intent to operate a child day center and other information as specified in § 63.2-1716 of the Code of Virginia and has a letter of exemption from the commissioner.

"Search of central registry" means the process the Virginia Department of Social Services' Child Protective Services Unit uses to generate a central registry report on a person.

~~"Sex offense felony for family day homes" means conviction of a felony in violation of §§ 18.2-48, 18.2-61, 18.2-63, 18.2-64.1, 18.2-67.1, 18.2-67.2, 18.2-67.3, 18.2-67.5, 18.2-355, 18.2-361, 18.2-366, 18.2-369, 18.2-370, 18.2-370.1, 18.2-371.1 or § 18.2-374.1 of the Code of Virginia that prohibits a sex offender or founded child abuser from residing~~

~~in a family day home, whether or not the home is regulated or subject to regulation. The descriptions of the Code of Virginia sections are abduction; actual or attempted rape; carnal knowledge of a child between 13 and 15 years of age; carnal knowledge of a juvenile under the purview of the Juvenile and Domestic Relations District Court, or juvenile committed to the custody of the State Department of Juvenile Justice; actual or attempted forcible sodomy or object sexual penetration; aggravated sexual battery; attempted sexual battery; taking or detaining a person or consenting to the taking of a person for prostitution or unlawful sexual intercourse; crimes against nature; incest; abuse and neglect of incapacitated adults; taking indecent liberties with children; abuse and neglect of children; indecent liberties by a person in a custodial or supervisory relationship; and production, publication, sale, possession with intent to distribute, financing, etc. of sexually explicit items.~~

"Sworn statement or affirmation" means a statement completed by a person attesting to whether he has ever been (i) convicted of or the subject of pending charges of any crime within or outside the Commonwealth or an equivalent offense outside the Commonwealth or (ii) the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth. Additionally for family day homes, the provider affirms if he, or any person known to the provider who resides in the home, has a sex offense conviction or is the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth. Any person making a false statement regarding any such offense shall be guilty of a Class 1 misdemeanor pursuant to §§ 63.2-1720 and 63.2-1721 of the Code of Virginia.

"22VAC" means Title 22 of the Virginia Administrative Code. This is the social services title.

"Visit" means a stay or sojourn as a guest for no longer than 30 calendar days.

"Volunteer" means a person who provides services without pay and who is alone with a child or children in performance of his duties.

22VAC40-191-50. Explaining requirements for satisfactory background checks.

A. The department and registering and approving authorities must require documentation of satisfactory background checks for applicants, agents, employees, volunteers, and others living in family day homes and foster and adoptive homes as specified in 22VAC40-191-40.

1. A satisfactory sworn statement or affirmation is:
 - a. A fully completed original that states that the person:
 - (1) ~~Does not have a criminal conviction that is a barrier crime or is any felony conviction within the last five years; and~~
 - (2) ~~Is not the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth; and does not have an offense; and~~

b. ~~When there~~ There is no other knowledge that the individual has an unsatisfactory background.

Criminal convictions include prior adult convictions and juvenile convictions or adjudications of delinquency based on a crime that would be a felony if committed by an adult within or outside the Commonwealth. Convictions also include convictions in other states that are equivalent to those specified in this section.

2. A satisfactory central registry finding is one in which:
 - a. A copy of the department's child protective services check form is returned to the requesting agency or state or local Department of Social Services indicating that, as of the date on the reply, the individual whose name was searched is not identified in the ~~Central Registry of Founded Child Abuse/Neglect Investigations~~ central registry as an involved caregiver with a founded disposition of child abuse/neglect; and
 - b. There is no other knowledge that the individual has a founded disposition in Virginia or elsewhere.
3. A satisfactory criminal history record check report is one in which:
 - a. An original hard copy or Internet inquiry reply from the Department of State Police is returned to the agency, individual or authorized agent making the request with:
 - (1) No convictions indicated; or
 - (2) Convictions indicated, but no barrier crimes, offenses, or other felony convictions in the last five years;
 - b. A letter is received from the Office of Background Investigations with a finding of "eligible"; and
 - c. There is no other knowledge that the individual has a ~~barrier crime, or other felony conviction in the past five years,~~ an offense in Virginia or elsewhere.

The facility must have viewed an original criminal history record report maintained by a contract employee or contract agency that is dated less than six months before the independent contract employee or contract employee is hired by a contract agency begins providing services at the facility. (See also 22VAC40-191-90.)

4. A child-placing agency may approve as an adoptive or foster parent an applicant convicted of not more than one misdemeanor of assault and battery, as defined in § 18.2-57 of the Code of Virginia, not involving abuse, neglect or moral turpitude, or a minor, provided 10 years have elapsed following the conviction.
5. A child-placing agency may approve as a foster parent an applicant convicted of statutory burglary for breaking and entering a dwelling home or other structure with intent to commit larceny who has had his civil rights restored by the Governor, provided 25 years have elapsed following the conviction.
6. A child-placing agency must consider the results of background checks on a birth parent prior to placing the

child of the birth parent with the birth parent, when the child is in a foster care placement (unless the birth parent has revoked an entrustment agreement pursuant to § 63.2-1223 or 63.2-1817 of the Code of Virginia or a local board or the birth parent revokes a placement agreement with legal custody remaining with the parent, parents, or guardians pursuant to § 63.2-900 of the Code of Virginia).

7. No petition for adoption shall be granted if an adoptive parent has been convicted of a sexually violent offense or an offense requiring registration pursuant to § 9.1-902 of the Code of Virginia.
8. A child-placing agency may approve as an adoptive or foster parent an applicant convicted of felony possession of drugs, who has had his civil rights restored by the Governor, provided 10 years have elapsed following the conviction.
9. A child-placing agency may approve as a kinship foster care parent an applicant convicted of the following offenses, provided that 10 years have elapsed from the date of the conviction and the local board or child-placing agency makes a specific finding that approving the kinship foster care placement would not adversely affect the safety and well-being of the child: (i) a felony conviction for possession of drugs as set out in Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2 of the Code of Virginia, but not including a felony conviction for possession of drugs with the intent to distribute; (ii) a misdemeanor conviction for arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2; or (iii) an equivalent offense in another state.
10. A licensed child day center may hire for compensated employment persons who have been convicted of not more than one misdemeanor offense as defined in § 18.2-57 of the Code of Virginia if 10 years have elapsed following the conviction, unless the person committed such offense while employed in a child day center or the object of the offense was a minor.

B. Background checks results are not open ended.

1. When a minor living in a family day home turns 18 years of age, the operator is responsible for making sure that the 18-year-old complies with all background check requirements for adults pursuant to 22VAC40-191-40 D 4.
2. Operators must submit new background checks as part of the renewal application packages of registered family day homes. With the exception of those facilities that are exempt per § 63.2-1716 of the Code of Virginia, background checks are required every three years for all other persons required to have background checks pursuant to 22VAC40-191-40 D.
3. If a person leaves a facility and the criminal history record report or central registry check finding is less than 91 days old, the person must be permitted to take the report or reports with him. The facility must keep a copy of any

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report a person takes and write on it that it is a copy, and that the original of any criminal history record report was verified.

4. Unless there is a criminal conviction or a founded complaint of child abuse and neglect during that period, a background check remains valid at a facility if no more than 12 consecutive months have passed from when a person:

- a. Began a leave of absence from that facility;
- b. Was terminated from employment at that facility; or
- c. Was transferred to a center owned and operated by the same employer or entity.

5. The facility, department, or registering or approving authority may require a new background check relevant to this suspicion if there is reason to suspect that a person who has submitted acceptable background checks, as required by this regulation, has:

- a. ~~A barrier crime conviction~~ an offense in Virginia or elsewhere;
- b. ~~A felony conviction that is not for a barrier crime within the last five years in Virginia or elsewhere; or~~
- e. ~~A founded complaint of child abuse and neglect in Virginia or elsewhere.~~

6. When the facility, department, or registering or approving authority chooses to require a new background check:

- a. The facility, department, or registering or approving authority may allow the person to continue the same relationship with the child welfare agency until the child care provider or licensing, registering, or approval authority receives the new Virginia background check information or equivalent documentation from another state; or
- b. If there is reason to suspect that a person has ~~a barrier crime conviction, a felony conviction in the last five years, or has a founded complaint of child abuse and neglect~~ an offense, the facility, department, or registering or approving authority may require that the person not be alone with children, even if the documentation is not Virginia background check information or equivalent information from another state.

C. Waivers of some criminal convictions are possible. Refer to 22VAC40-191-90 through 22VAC40-191-130 for an explanation of the waiver.

VA.R. Doc. No. R17-4657; Filed August 18, 2016, 10:52 a.m.

Proposed Regulation

Title of Regulation: **22VAC40-325. Fraud Reduction/Elimination Effort (amending 22VAC40-325-20).**

Statutory Authority: §§ 63.2-217 and 63.2-526 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: November 18, 2016.

Agency Contact: Toni Blue Washington, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7662, FAX (804) 726-7669, or email toni.washington@dss.virginia.gov.

Basis: Section 63.2-217 of the Code of Virginia gives the State Board of Social Services authority to promulgate regulations necessary to carry out Title 63.2 of the Code of Virginia. Section 63.2-526 sets forth the provisions for a statewide fraud control program and requires the State Board of Social Services to adopt regulations to implement the provisions of the section.

Purpose: The regulation relates to the administration of the fraud program by the state and local departments of social services. The proposed revisions will more accurately define the local administrative allocation and reimbursement practices related to local fraud activities. Local fraud prevention and detection activities are paramount to ensuring public assistance programs serve only those actually in need of assistance. By ensuring that limited funding is available only to those in need, the health, safety, and welfare of Virginia's citizens are protected.

Substance: The proposed amendments revise the provisions pertaining to local allocations and reimbursement of fraud control activities to reflect current practices. Beginning in state fiscal year 2014, the Department of Social Services (DSS) moved to a single random moment sampling (RMS) funding pool for all local administrative activities, rather than two funding pools, one for benefit programs and one for family services. As a result, reimbursement is made to local departments from the appropriation for financial assistance for local social services staff and operations based on the DSS federally approved cost allocation plan. RMS allows local departments to accurately document staff activities relating to reimbursable federal programs. RMS sampling is a recognized and accepted alternative to burdensome 100% time reporting. Language in the current regulation does not accurately reflect the change in local funding allocations and reimbursements.

The proposed amendments incorporate the specific methodology for the funding allocation. Each local department's allocation will be determined as follows: 40% on the local department's Temporary Assistance for Needy Families, food stamp, energy assistance, and child care caseload; 20% on the number of completed investigations; 20% on the number of established claims; and 20% on the actual collections from established claims.

Issues: The proposed amendments clarify the current regulation to state the specific funding methodology used to allocate funds to local agencies. Additionally, the proposed amendments correct the statement that reimbursements to local agencies are based on the formula. In 2014, DSS

changed its funding methodology for local social services staff to a single pool. As a result, reimbursement is made to local agencies based on the DSS federally approved cost allocation plan from funds appropriated for local social services staff and operations as set forth in the Virginia appropriations act. The primary advantage of the action to the public and local departments is having a clear regulatory base for the methodology that is consistent with practice. There are no disadvantages.

Small Business Impact Review Report of Findings: This proposed regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. As a result of a periodic review, the State Board of Social Services (Board) proposes to amend its fraud reduction/elimination effort regulation to delineate the methodology used to reimburse local Departments of Social Services for conducting fraud prevention, detection and investigation activities.

Result of Analysis. Benefits likely outweigh costs for these proposed changes.

Estimated Economic Impact. Current regulation allows reimbursement to local Departments of Social Services (LDSS) and states that such reimbursement will be made according to a methodology "as developed by the work group convened by the commissioner, consisting of local department representatives and senior department managers." Board staff reports that, in 2014, the source of reimbursements for such fraud reduction/elimination efforts was changed to a single pool of money. As a consequence, reimbursements were no longer made according to the methodology in the current regulation. Instead, reimbursements are made to LDSSs based on the State Department of Social Services' federally approved cost allocation plan from funds appropriated, and operations set forth, in Virginia's Appropriation Act.

In response to these changes, the Board now proposes to eliminate obsolete language that no longer reflects how reimbursements are made to LDSSs and add language that delineates the current formula for reimbursement. Specifically, 40% of LDSS reimbursement is based on Temporary Aid to Needy Families (TANF), food stamp, energy assistance and child care caseloads. Additionally, 20% is based on the number of investigations completed each year, 20% is based on the number of established claims of fraud and 20% is based the actual collections from established claims. The Board proposes to add this new formula, which has been in use since 2014, to the regulation. No entity is likely to incur costs on account of this proposed regulatory change. To the extent that this proposal removes obsolete

language and adds currently relevant information to this regulation, interested parties are likely to benefit.

Businesses and Entities Affected. Board staff reports that this proposed regulation will affect all 120 LDSSs.

Localities Particularly Affected. No locality will be particularly affected by this regulatory change.

Projected Impact on Employment. This proposed regulatory change is unlikely to have any impact on employment in the Commonwealth.

Effects on the Use and Value of Private Property. This proposed regulation is unlikely to have any impact on the use or value of private property.

Real Estate Development Costs. This proposed regulation is unlikely to affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. No small businesses in the Commonwealth are likely to incur costs on account of this proposed regulation.

Alternative Method that Minimizes Adverse Impact. No small businesses in the Commonwealth are likely to incur costs on account of this proposed regulation.

Adverse Impacts:

Businesses. No businesses in the Commonwealth are likely to incur costs on account of this proposed regulation.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of this proposed regulatory change.

Other Entities. No other entities are likely to suffer any adverse impact on account of this proposed regulation.

Agency's Response to Economic Impact Analysis: The Department of Social Services concurs with the June 2, 2016, economic impact analysis prepared by the Department of Planning and Budget.

Summary:

The proposed amendments update the regulation and incorporate the specific funding methodology used to allocate funds to local departments of social services for fraud prevention, detection, and investigation activities.

22VAC40-325-20. The Fraud Reduction/Elimination Effort.

A. In compliance with § 63.2-526 of the Code of Virginia, the department shall establish a statewide fraud prevention, detection, and investigation program to be named the Fraud Reduction/Elimination Effort (FREE).

1. The department shall develop and implement policies and procedures for the FREE program.

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2. The department shall provide a detailed local reimbursement procedure, on an annual basis, to assist in the formulation of the local department's FREE program operation plan. The department's procedure shall project the available funding and the number of local fraud investigators for each local department that the FREE program will support. The number of investigators shall be based on an evaluation of the available funding and appropriate criteria from one or more of the following: a local department's average TANF and Food Stamp caseload size, average number of monthly applications for food stamps and TANF, number of local department workers, geographic location, number of fraud investigations, program compliance, collections, and performance expectations.

3. The department shall develop, implement, and monitor local FREE units performance expectations.

B. Each local department shall aggressively pursue fraud prevention, detection, and investigations.

1. Each local department shall conduct fraud prevention, detection, and investigation activities consistent with the requirements of federal regulations, the Code of Virginia, ~~the regulations contained herein~~ this chapter, and the department's FREE program policy.

2. Each local department shall submit to the department, for annual approval, a program operation plan, formatted by the department, which shall include a description of the local department's prevention, detection, and investigative process; an agreement with the Commonwealth's attorney; identification of staff charged with oversight or supervisory responsibility of the FREE program; a performance expectation monitoring process; a signed commitment to adhere to specified responsibilities identified in the Statement of Assurance section of the program operation plan; and, if requested, a proposed annual budget to include the identification of the FREE program investigators, their salary, fringe benefit amounts, supporting operating costs, hours worked per week, and time dedicated to the FREE program.

3. Upon request, each local department shall provide the department with an accounting of FREE program expenditures.

C. Funding for the FREE program shall be comprised of balances in the Fraud Recovery Special Fund, general funds appropriated for this activity, and any federal funds available for this purpose.

1. In order to receive reimbursement of direct costs and supporting costs of operation, a local department must:

- a. Comply with all pertinent law, regulation, and policy;
- b. In accordance with the law, each local department shall establish and maintain a FREE prevention, detection, and investigation unit; and

c. Recover fraud-related and nonfraud-related overpayments of designated federal assistance programs. ~~Reimbursement~~ An allocation to localities shall be made in accordance with the following methodology ~~for the allocation of funds to localities as developed by the work group convened by the commissioner, consisting of local department representatives and senior department managers~~: 40% based on each agency's Temporary Assistance for Needy Families, food stamp, energy assistance, and child care caseload; 20% based on the number of investigations completed; 20% based on the number of established claims; and 20% based on the actual collections from established claims. Each local department's level of reimbursement of direct and support operation costs is paid from available federal funds, ~~general funds and state retained portion of collections~~ department is reimbursed for fraud-related expenses through funds appropriated for local social services staff and operations.

2. Local departments may contract with other local departments to share a fraud prevention, detection, and investigation unit and may contract with private entities to perform fraud investigations. Any private entity performing fraud investigations shall comply with the requirements of § 30-138 of the Code of Virginia and the restrictions of § 63.2-526 of the Code of Virginia.

VA.R. Doc. No. R16-4195; Filed August 19, 2016, 3:58 p.m.

DEPARTMENT FOR THE BLIND AND VISION IMPAIRED

Final Regulation

Titles of Regulations: **22VAC45-50. Regulation Governing Provisions of Services in Vocational Rehabilitation (repealing 22VAC45-50-10 through 22VAC45-50-150).**

22VAC45-51. Regulations Governing Provisions of Services in Vocational Rehabilitation (adding 22VAC45-51-10 through 22VAC45-51-140).

Statutory Authority: § 51.5-66 of the Code of Virginia.

Effective Date: October 19, 2016.

Agency Contact: Susan D. Payne, Program Director, Vocational Rehabilitation, Department for the Blind and Vision Impaired, 397 Azalea Avenue, Richmond, VA 23227, telephone (804) 371-3184, FAX (804) 371-3351, TTY (804) 371-3140, or email susan.payne@dbvi.virginia.gov.

Summary:

The action replaces existing regulations governing vocational rehabilitation services (22VAC45-50) with new regulations (22VAC45-51) that are reorganized and updated to comport with federal requirements, remove duplicative provisions, and remove agency policy language. In addition, the language pertaining to provision of services for American Indians is repealed because the language only applies to federally recognized Indian tribes

and Virginia has no such tribes. The only change since the proposed stage is the addition of a qualified optometrist as evaluator of an individual's eye condition in order to qualify for vocational rehabilitation services.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

CHAPTER 51
REGULATIONS GOVERNING PROVISION OF
SERVICES IN VOCATIONAL REHABILITATION

22VAC45-51-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless the context clearly states otherwise:

"Applicant" means an individual who submits an application for vocational rehabilitation services.

"Appropriate modes of communication" means specialized aids and supports that enable an individual with a disability to comprehend and respond to information that is being communicated. Appropriate modes of communication include, but are not limited to, the use of interpreters, open and closed captioned videos, specialized telecommunication services and audio recordings, Brailed and large print materials, materials in electronic formats, augmentative communication devices, graphic presentations, and simple language materials.

"Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of an individual with a disability.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device including:

1. The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in his customary environment;
2. Purchasing, leasing, or otherwise providing for the acquisition by an individual with a disability of an assistive technology device;
3. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing educational and rehabilitation plans and programs;
5. Training or technical assistance for an individual with a disability or, if appropriate, the family members,

guardians, advocates, or authorized representatives of the individual; and

6. Training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or others who provide services to, employ, or are otherwise substantially involved in the major life functions of individuals with disabilities to the extent that training or technical assistance is necessary to the achievement of an employment outcome by an individual with a disability.

"Blind" means having not better than 20/200 central visual acuity in the better eye measured at 20 feet with correcting lenses or having visual acuity greater than 20/200 but with the widest diameter of the visual field in the better eye subtending an angle of no greater than 20 degrees, measured at a distance of 33 centimeters using a three-millimeter white-test object, a Goldman III-4e target, or other equivalent equipment. Such blindness shall be certified by a duly licensed physician or optometrist. (§ 51.5-60 of the Code of Virginia)

"Client assistance program" means the program located within the disAbility Law Center of Virginia for the purpose of advising applicants or eligible individuals about all available services under the Rehabilitation Act, as amended by the Workforce Innovation and Opportunity Act of 2014 (29 USC § 3101 et seq.), as amended, and to assist them in their relationship with programs, projects, and facilities providing rehabilitation services.

"Community rehabilitation program" means a program that provides directly or facilitates the provision of one or more of the allowable vocational rehabilitation services to individuals with disabilities to enable those individuals to maximize their opportunities for employment, including career advancement.

"Comparable services and benefits" means services and benefits that are (i) provided or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits; (ii) available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual's individualized plan for employment; and (iii) commensurate to the services that the individual would otherwise receive from the designated state vocational rehabilitation agency. For the purposes of this definition, comparable benefits do not include awards and scholarships based on merit.

"Competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting and 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 who are not disabled.

"DBVI" means the Department for the Blind and Vision Impaired.

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"Eligible individual" means an applicant for vocational rehabilitation services who meets the eligibility requirements in 22VAC45-51-40.

"Employment outcome" means, with respect to an individual, entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market to the greatest extent practicable, supported employment, or any other type of employment, including self-employment, telecommuting, or business ownership, that is consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

"Extended employment" means work in a nonintegrated or sheltered setting for a public or private nonprofit agency or organization that provides compensation in accordance with the Fair Labor Standards Act (29 USC § 201 et seq.) and any needed support services to an individual with a disability to enable the individual to continue to train or otherwise prepare for competitive employment, unless the individual through informed choice chooses to remain in extended employment.

"Extended services," as used in the definition of "supported employment," means ongoing support services and other appropriate services that are needed to support and maintain an individual with a most significant disability in supported employment and that are provided by a state agency, a private nonprofit organization, an employer, or any other appropriate resource from funds other than funds received under 34 CFR Part 361 and 34 CFR Part 363 after an individual with a most significant disability has made the transition from support provided by DBVI.

"Family member" for the purposes of receiving vocational rehabilitation services means an individual who is either a relative or guardian of an applicant or eligible individual or lives in the same household as an applicant or eligible individual who has a substantial interest in the well-being of that individual and whose receipt of vocational rehabilitation services is necessary to enable the applicant or eligible individual to achieve an employment outcome.

"Financial need test" means the test developed by DBVI and used to consider the financial need of applicants or eligible individuals with blindness or visual impairment for the purpose of determining the extent of their participation in the costs of vocational rehabilitation services.

"Impartial hearing officer" means an individual who is not an employee of a public agency other than an administrative law judge, hearing examiner, or employee of an institution of higher education; is not a member of the State Rehabilitation Council for the Blind and Vision Impaired; has not been involved previously in the vocational rehabilitation of the applicant or eligible individual; has knowledge of the delivery of vocational rehabilitation services, the state plan, and the federal and state regulations governing the provision of services; has received training with respect to the performance of official duties; and has no personal,

professional, or financial interest that would be in conflict with the objectivity of the individual. An individual is not considered to be an employee of DBVI for the purposes of this definition solely because the individual is paid by the DBVI to serve as a hearing officer (34 CFR 361.5(b)(25)).

"Individual's representative" means any representative chosen by an applicant or eligible individual, as appropriate, including a parent, guardian, other family member, or advocate, unless a representative has been appointed by a court to represent the individual, in which case the court-appointed representative is the individual's representative.

"Individual with a most significant disability" means an individual who has no functional vision or is significantly visually impaired; has a secondary disability that profoundly limits two or more life activities, such as mobility, communication, self-care, interpersonal skills, self-direction, work tolerance, or work skills in terms of achieving an employment outcome; and the individual's vocational rehabilitation is expected to require three or more vocational rehabilitation services for one year or more.

"Individual with a significant disability" means the significant visual impairment does not enable the individual to obtain a driver's license in Virginia with normal correction; "seriously limits" one or more life activities, such as mobility, communication, self-care, interpersonal skills, self-direction, work tolerance, or work skills, in terms of achieving an employment outcome; and the individual's vocational rehabilitation shall require two or more substantial vocational rehabilitation services for a minimum of three months.

"Individualized plan for employment" or "IPE" means a unique plan for employment that is customized for each eligible individual receiving vocational rehabilitation services.

"Integrated setting," with respect to the provision of services, means a setting typically found in the community in which applicants or eligible individuals interact with nondisabled individuals, other than nondisabled individuals who are providing services to those applicants or eligible individuals, to the same extent that nondisabled individuals in comparable positions interact with other persons.

"Maintenance" means monetary support provided to an individual for expenses, such as food, shelter, and clothing, that are in excess of the normal expenses of the individual and that are necessitated by the individual's participation in an assessment for determining eligibility and vocational rehabilitation services under an individualized plan for employment.

"Mediation" means the act or process of using an independent third party to act as a mediator, intermediary, or conciliator to assist persons or parties in settling differences or disputes prior to pursuing formal administrative or other remedies.

"One-stop center" means a center designed to provide a full range of assistance to job seekers under one roof. Established under the Workforce Innovation and Opportunity Act of 2014 (29 USC § 3101 et seq.), the centers offer training, career counseling, job listings, and similar employment-related services.

"On-the-job training" means job training received in a real work environment for individuals who are job ready.

"Ophthalmologist" means a physician specializing in diseases of the eye.

"Optometrist" means any person practicing the profession of optometry as defined by § 54.1-3200 of [the] the Code of Virginia and regulations of the Board of Optometry (18VAC105-20).

"Order of selection" means the order defined in the state plan for vocational rehabilitation services that DBVI shall follow in selecting eligible individuals to be provided vocational rehabilitation services when DBVI determines that it is unable to provide the full range of vocational rehabilitation services to all eligible individuals.

"Personal assistance services" means a range of services provided by one or more persons designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability. The services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job. These services shall be necessary to the achievement of an employment outcome and may be provided only while the individual is receiving other vocational rehabilitation services. These services may include training in managing, supervising, and directing personal assistance services.

"Personal information" means all information that describes, locates, or indexes anything about an individual including (i) social security number, driver's license number, agency-issued identification number, student identification number, or real or personal property holdings derived from tax returns and (ii) education, financial transactions, medical history, or employment record.

"Post-employment services" means one or more of the services identified in 22VAC45-51-80 that are provided subsequent to the achievement of an employment outcome and that are necessary for an individual to maintain, regain, or advance in employment, consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

"Profoundly limits" means the individual is unable to use vision (with or without visual aids) to assist him in performing such functions as mobility, communication, self-care, interpersonal skills, self-direction, work tolerance, or work skills and the individual has not acquired the adaptive skills to compensate for the lack of functional vision.

"Qualified and impartial mediator" means an individual who is not an employee of a public agency other than an administrative law judge, hearing examiner, employee of a state office of mediators, or employee of an institution of higher education; is not a member of the State Rehabilitation Council for the Blind and Vision Impaired; has not been involved previously in the vocational rehabilitation of the applicant or eligible individual; is knowledgeable of the vocational rehabilitation program and the applicable federal and state laws, regulations, and policies governing the provision of vocational rehabilitation services; has been trained in effective mediation techniques consistent with any state-approved or recognized certification, licensing, registration, or other requirements; and has no personal, professional, or financial interest that would be in conflict with the objectivity of the individual during the mediation proceedings. An individual serving as a mediator is not considered to be an employee of DBVI for the purposes of this definition solely because the individual is paid by DBVI to serve as a mediator.

"Rehabilitation technology" means the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of, and address the barriers confronted by, individuals with disabilities in areas that include education, rehabilitation, employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.

"Seriously limits" means an individual has some functional vision (with or without visual aids) that is used by the individual in performing such functions as mobility, communication, self-care, interpersonal skills, self-direction, work tolerance, or work skills and the individual has not acquired the adaptive skills to compensate for the limited functional vision.

"Significant visual impairment" means vision worse than 20/70 in the better eye with correction or a field of vision restricted to less than 70 degrees in the better eye.

"Supported employment" means (i) competitive work in an integrated setting or employment in integrated work settings in which individuals are working toward competitive employment, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual with ongoing support services for individuals with the most significant disabilities for whom competitive employment has not traditionally occurred or for whom competitive employment has been interrupted or intermittent as a result of a significant disability, and who, because of the nature and severity of their disabilities, need intensive supported employment services from DBVI and extended services after transition to perform this work or (ii) transitional employment for individuals with the most significant disabilities due to mental illness.

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"Transition services" means a coordinated set of activities for a student designed within an outcome-oriented process that promotes movement from school to post-school activities, including post-secondary education, vocational training, and integrated employment (including supported employment), continuing adult education, adult services, independent living, or community participation.

"Transportation" means travel and related expenses that are necessary to enable an applicant or eligible individual to participate in a vocational rehabilitation service, including expenses for training in the use of public transportation vehicles and systems.

"Vocational rehabilitation services" or "services" means goods and services that are available to assist the individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice as described in 22VAC45-51-70 and 34 CFR 361.48.

"Work adjustment training" means a training process utilizing individual and group work or work-related activities to assist individuals in understanding the meaning, value, and demands of work; to modify or develop attitudes, personal characteristics, and work behavior; and to develop functional capacities, as required, in order to assist individuals toward their optimum level of vocational development.

22VAC45-51-20. Protection, use, and release of personal information (34 CFR 361.38).

A. General provisions. DBVI shall safeguard the confidentiality of all personal information, including photographs and lists of names to ensure that:

1. Current and stored personal information is protected;
2. All applicants and eligible individuals and, as appropriate, those individuals' representatives, service providers, cooperating agencies, and interested persons are informed through appropriate modes of communication of the confidentiality of personal information and the conditions for accessing and releasing this information;
3. All applicants or their representatives are informed about DBVI's need to collect personal information and the policies governing its use including:
 - a. The purposes for which DBVI intends to use or release the information;
 - b. An explanation of whether providing requested information is mandatory or voluntary and the effects of not providing requested information;
 - c. Identification of those situations in which DBVI requires or does not require the informed written consent of the individual before information may be released; and
 - d. Identification of other agencies to which information is routinely released; and

4. An explanation of DBVI policies and procedures affecting personal information shall be provided to each individual in that individual's native language or through the appropriate mode of communication.

B. All personal information in the possession of DBVI shall be used only for the purposes directly connected with the administration of the DBVI vocational rehabilitation program. Information containing identifiable personal information shall not be shared with advisory or other bodies that do not have official responsibility for the administration of the program. In the administration of the program, DBVI may obtain personal information from service providers and cooperating agencies under assurances that the information shall not be further disclosed except as described in subsection A of this section.

C. Release to applicants and eligible individuals.

1. When requested in writing, DBVI shall make all requested information in that individual's record of vocational rehabilitation services accessible to and shall release the information to the individual or the individual's representative promptly.

2. Medical, psychological, or other information that DBVI determines may be harmful to the individual shall not be released directly to the individual but shall be provided to the individual through a third party chosen by the individual, which may include an advocate, family member, or medical or mental health professional. If a representative has been appointed by a court to represent the individual, the information shall be released to the court-appointed representative.

3. Personal information obtained by DBVI from another agency or organization may be released only by, or under conditions established by, the other agency or organization.

D. Release for audit, evaluation, and research. DBVI may release personal information to an organization, agency, or individual engaged in audit, evaluation, or research only for purposes directly connected with the administration of the vocational rehabilitation program, or for purposes that would significantly improve the quality of life for applicants and eligible individuals and only if the organization, agency, or individual assures that:

1. The information shall be used only for the purposes for which it is being provided;
2. The information shall be released only to persons officially connected with the audit, evaluation, or research;
3. The information shall not be released to the involved individual;
4. The information shall be managed in a manner to safeguard confidentiality; and
5. The final product shall not reveal any identifying personal information without the informed written consent of the involved individual or the individual's representative.

E. Release to other programs or authorities.

1. Upon written consent of the individual or, if appropriate, the individual's representative, DBVI shall release personal information to another agency or organization for its program purposes only to the extent that the information shall be released to the involved individual or the individual's representative and only to the extent that the other agency or organization demonstrates that the information is necessary for its program.

2. Medical or psychological information that DBVI determines may be harmful to the individual shall be released if the other agency or organization assures DBVI that the information shall be used only for the purpose for which it is being provided and that it shall not be further released to the individual.

F. DBVI shall release any personal information required by federal and state laws or regulations.

G. DBVI shall release personal information in response to investigations in connection with law enforcement, fraud, or abuse, unless expressly prohibited by federal or state laws or regulations, and in response to an order issued by a judge, magistrate, or other authorized judicial officer.

H. DBVI shall also release personal information in order to protect the individual or others if the individual poses a threat to his safety or to the safety of others.

I. DBVI shall release to the Governor or his designee a complete and certified copy of the case record including transcripts of a fair hearing decision for the purpose of the Governor's review of an impartial hearing officer's final decision when one of the parties to a fair hearing requests a review.

22VAC45-51-30. Processing referrals and application.

A. DBVI has established and implemented standards for the prompt and equitable handling of applications of individuals for vocational rehabilitation services. These standards include timelines for making good faith efforts to inform individuals of application requirements and to gather information necessary to initiate an assessment for determining eligibility and priority for services.

1. An individual shall be considered to have submitted an application for vocational rehabilitation services from DBVI when the individual or the individual's representative, as appropriate:

- a. Has completed and signed a DBVI vocational rehabilitation services application form, which is available at the six DBVI regional offices, DBVI Headquarters, and on the DBVI website;
- b. Has completed a common intake application form in a one-stop center requesting vocational rehabilitation services; or
- c. Has otherwise requested vocational rehabilitation services from DBVI; and

2. Has provided to DBVI information necessary to initiate an assessment to determine eligibility and priority for vocational rehabilitation services; and

3. Is available to complete the assessment process.

B. Once an individual has submitted an application for vocational rehabilitation services, including applications made through common intake procedures in one-stop centers established under § 121 of the Workforce Innovation and Opportunity Act of 2014, an eligibility determination shall be made within 60 days, unless (i) exceptional and unforeseen circumstances beyond the control of DBVI preclude making a determination within 60 days, and DBVI and the individual agree to a specific extension of time or (ii) an exploration of the individual's abilities, capabilities, and capacity to perform in work situations is carried out in accordance with 22VAC45-51-40 or, if appropriate, an extended evaluation is necessary.

22VAC45-51-40. Eligibility for vocational rehabilitation services.

A. The DBVI Vocational Rehabilitation Program shall serve only individuals who are blind or who have significant visual impairment and have attained the age of 14 years. DBVI and the Virginia Department for Aging and Rehabilitative Services shall identify client populations served by each agency through a cooperative agreement.

B. Any qualified applicant residing in Virginia shall be served by the DBVI Vocational Rehabilitation Program. Services may be provided to otherwise qualified non-U.S. citizens who can produce a permanent or working visa, or their green card registration number. Copies of these documents shall be retained in the applicant's case service record.

C. DBVI shall conduct an initial assessment to determine whether an applicant is eligible for vocational rehabilitation services and to determine the individual's priority under an order of selection for services if DBVI is operating under an order of selection pursuant to 22VAC45-51-60. The initial assessment must be conducted in the most integrated setting possible, consistent with the individual's needs and informed choice. The applicant for vocational rehabilitation services may use a qualified service provider of his choice in obtaining necessary assessments to determine eligibility for services and priority for services.

D. Qualified applicants shall be assessed as meeting the following eligibility criteria to receive vocational rehabilitation services from DBVI:

1. The [~~applicant~~ individual] shall meet the criteria of being blind or visually impaired through one or more of the following:

- a. The individual has a visual impairment that results in functional limitations related to obtaining, regaining, or maintaining employment and causes the individual to require the specialized services available through DBVI;

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b. The individual [~~has a rapidly progressive eye condition that~~], in the opinion of a qualified ophthalmologist [~~will~~ or optometrist, has a rapidly progressive eye condition that causes or shall] cause the individual to experience functional limitations related to obtaining, regaining, or maintaining employment and causes the individual to require the specialized services available through DBVI [~~;~~] or

c. The individual is in a situation where eye treatment or surgery, or both, are recommended and there are functional limitations in performing employment duties.

2. The individual's blindness or visual impairment shall constitute or result in a substantial impediment to employment.

3. The individual shall require vocational rehabilitation services to prepare for, secure, retain, or regain employment.

4. The individual shall be able to benefit in terms of an employment outcome from the provision of vocational rehabilitation services.

E. Applicants who are unemployed, underemployed, or in unstable employment as determined by the DBVI vocational rehabilitation counselor meet the requirement that there exists a substantial impediment to employment.

F. A beneficiary of social security benefits due to blindness under Title II or XVI of the Social Security Act shall be presumed eligible for DBVI vocational rehabilitation services under subsection D of this section provided the individual intends to achieve an employment outcome consistent with the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual.

G. Vocational rehabilitation services shall not be provided to a potentially eligible individual on the basis of an interim determination of eligibility.

22VAC45-51-50. Comprehensive assessment of qualifications for individualized plans of employment.

Once it is determined that an individual is eligible for DBVI vocational rehabilitation services, to the extent additional data are necessary to make a determination of the employment outcomes and the nature and scope of vocational rehabilitation services to be included in the individualized plan for employment of an eligible individual, a comprehensive assessment shall be conducted to determine the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice, including the need for supported employment, of the individual. This comprehensive assessment:

1. Shall be limited to information that is necessary to identify the rehabilitation needs of the individual and to develop the individualized plan of employment of the eligible individual.

2. Shall be used as a primary source of information to the maximum extent possible, as appropriate, and in accordance with confidentiality requirements may include:

a. Existing information obtained for the purposes of determining the eligibility of the individual and assigning priority for an order of selection for the individual; and

b. Information that can be provided by the individual and, if appropriate, by the family of the individual.

3. May include, to the degree needed to make such a determination, an assessment of the personality, interests, interpersonal skills, intelligence and related functional capacities, educational achievements, work experience, vocational aptitude, personal and social adjustments, and employment opportunities of the individual and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational, and environmental factors that affect the employment and rehabilitation needs of the individual.

4. May include, to the degree needed, an appraisal of the patterns of work behavior of the individual and vocational rehabilitation services needed for the individual to acquire occupational skills and to develop work attitudes, work habits, work tolerance, and social and behavior patterns necessary for successful job performance, including the use of work in a real job situation to assess and develop the capacities of the individual to perform adequately in a work environment.

5. May include referral for the provision of rehabilitation technology services to the individual to assess and develop the capacities of the individual to perform in a work environment.

6. May include an exploration of the individual's abilities, capabilities, and capacity to perform in work situations, which must be assessed periodically during trial work experiences, including experiences in which the individual is provided appropriate supports and training.

22VAC45-51-60. Order of selection for services.

A. When DBVI is unable to serve all potentially eligible individuals due to insufficient funds, an order of selection for vocational rehabilitation services shall be implemented. The order of selection shall consist of a group of categories that designate who shall be served first based on:

1. The individual's blindness or visual impairment including secondary disabling conditions;

2. Whether the individual's blindness or visual impairment profoundly or significantly limits one or more life activities such as mobility, communication, self-care, interpersonal skills, self-direction, work tolerance, or work skills in terms of achieving an employment outcome; and

3. The number of vocational rehabilitation services required over an extended period of time.

B. When an order of selection must be instituted, DBVI shall:

1. Consult with the State Rehabilitation Council for the Blind and Vision Impaired regarding (i) the need to establish an order of selection, (ii) establishment of categories in the order of selection, (iii) establishment of criteria for each category, and (iv) administration of the order of selection;
2. Conduct a public hearing prior to implementation of the order of selection;
3. Continue to provide services to all individuals currently receiving services under an individualized plan for employment;
4. Provide assessment services to determine eligibility for individuals who apply for services;
5. Provide referral services to individuals who apply for services;
6. Identify service and outcome goals and the time within which the goals may be achieved for individuals in each priority category within the order; and
7. Assure that:
 - a. Individuals with the most significant disabilities shall be selected first for the provision of vocational rehabilitation services; and
 - b. Individuals who do not meet the criteria for the categories being served shall have access to services provided through the information and referral system.

22VAC45-51-70. Scope of vocational rehabilitation services for individuals who are blind or vision impaired.

The following vocational rehabilitation services shall be available to assist individuals who are blind or visually impaired in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice:

1. An initial assessment for determining eligibility and priority for vocational rehabilitation services conducted by a DBVI vocational rehabilitation counselor, including, if appropriate, an initial assessment in rehabilitation technology;
2. A comprehensive assessment for determining vocational rehabilitation needs conducted by a DBVI vocational rehabilitation counselor, including, if appropriate, an assessment by other DBVI staff skilled in rehabilitation technology;
3. Vocational rehabilitation counseling and guidance, including information and support services to assist an individual in exercising informed choice;
4. Referrals and other services necessary to assist applicants and eligible individuals to secure needed services from other agencies, including other components of the statewide workforce investment system and to

advise those individuals about the client assistance program established within the disAbility Law Center of Virginia;

5. Physical and mental restoration services, to the extent that financial support is not readily available from a source other than DBVI, such as through health insurance or other comparable services and benefits;
6. Vocational and other training services, including personal and vocational adjustment training, books, tools, and other training materials, except for training or training services in an institution of higher education (i.e., universities, colleges, community colleges, junior colleges, vocational schools, technical institutes, or hospital schools of nursing), that may be paid for with funds under this chapter only if maximum efforts have been made by DBVI and the individual to secure grant assistance in whole or in part from other sources to pay for that training and they are not available;
7. Maintenance, as defined in 22VAC45-51-10;
8. Transition services, which are a coordinated set of activities based on the individual student's needs, taking into account the student's preferences and interests, and including instruction, community experiences, development of employment and other post-secondary adult living objectives and, if appropriate, acquisition of daily living skills and functional vocational evaluation. Transition services must promote or facilitate the achievement of the employment outcome identified in the student's individualized plan for employment (34 CFR 361.5(b)(55));
9. Transportation, as defined in 22VAC45-51-10;
10. Vocational rehabilitation services to family members as defined in 22VAC45-51-10 if necessary to enable the applicant or eligible individual to achieve an employment outcome;
11. Interpreter services, including sign language and oral interpreter services, for individuals who are deaf or hard of hearing and tactile interpreting services for individuals who are deafblind;
12. Reader services, rehabilitation teaching services, and orientation and mobility services for individuals who are blind;
13. Job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services;
14. Supported employment services as defined in 22VAC45-51-10;
15. Personal assistance services as defined in 22VAC45-51-10;
16. Post-employment services as defined in 22VAC45-51-10;

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17. Occupational licenses, tools, equipment, initial stocks, and supplies;

18. Rehabilitation technology as defined in 22VAC45-51-10 including vehicular modification, telecommunications, sensory, and other technology aids and services;

19. Transition services as defined in 22VAC45-51-10;

20. Technical assistance and other consultation services to conduct market analyses and develop business plans for individuals who are pursuing self-employment or telecommuting or establishing a small business operation as an employment outcome; and

21. Other goods and services determined necessary for the individual who is blind or visually impaired to achieve an employment outcome.

22VAC45-51-80. Development of the individualized plan for employment.

A. General requirements.

1. As described in 22VAC45-51-50, DBVI shall conduct an assessment for determining vocational rehabilitation needs, if appropriate, for each eligible individual, or if DBVI is operating under an order of selection, for each eligible individual to whom DBVI is able to provide vocational rehabilitation services. The purpose of the assessment is to determine the employment outcome and the nature and scope of vocational rehabilitation services to be included in the individualized plan for employment.

2. The IPE shall be developed and implemented within 90 days for each individual determined eligible for vocational rehabilitation services, or if DBVI is operating under an order of selection, for each eligible individual to whom DBVI is able to provide vocational rehabilitation services. DBVI shall take into consideration the needs of the individual and if an IPE cannot be developed within 90 days because a vocational goal cannot yet be established, DBVI and the individual shall agree upon an extension.

3. Vocational rehabilitation services shall be provided in accordance with the provisions of the IPE.

4. The IPE shall:

a. Be designed to achieve the specific employment outcome selected by the individual consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; and

b. To the maximum extent appropriate, result in employment in an integrated setting.

B. Required information. DBVI shall provide information to each eligible individual or, as appropriate, the individual's representative, in writing and, if appropriate, in the native language or mode of communication of the individual or the individual's representative, including:

1. Available options for developing the IPE, including the option that an eligible individual or, as appropriate, the

individual's representative may develop all or part of the IPE:

a. Without assistance from DBVI or other entity; or

b. With assistance from:

(1) A DBVI vocational rehabilitation counselor;

(2) A vocational rehabilitation counselor who is not employed by DBVI; and

(3) Resources other than those in subdivisions 1 b (1) and 1 b (2) of this subsection.

2. Additional information to assist the eligible individual or, as appropriate, the individual's representative in developing the IPE, including:

a. Information describing the full range of components that shall be included in an IPE;

b. As appropriate to each eligible individual:

(1) An explanation of DBVI guidelines and criteria for determining an eligible individual's financial commitments under an IPE;

(2) Information on the availability of assistance in completing DBVI forms required as a part of the IPE; and

(3) Additional information that the eligible individual requests or DBVI determines to be necessary to the development of the IPE.

c. A description of the rights and remedies available to the individual including recourse to the processes for review of DBVI determinations described in 22VAC45-51-140; and

d. A description of availability of the client assistance program within the disAbility Law Center of Virginia and information on how to contact that office.

C. IPE requirements:

1. The IPE shall be a written document prepared on forms provided by DBVI.

2. The IPE shall be developed and implemented in a manner that gives individuals the opportunity to exercise informed choice in selecting:

a. The employment outcome, including the employment setting;

b. The specific vocational rehabilitation services to achieve the employment outcome, including the settings in which vocational rehabilitation services will be provided;

c. The entity or entities that will provide the vocational rehabilitation services; and

d. The methods available for procuring the vocational rehabilitation services.

3. The IPE shall be:

a. Agreed to and signed by the eligible individual or, as appropriate, the individual's representative; and

- b. Approved and signed by a DBVI vocational rehabilitation counselor.
- 4. DBVI shall provide a copy of the IPE and a copy of amendments to the IPE to the eligible individual or, as appropriate, to the individual's representative, in writing and, if appropriate, in the native language or mode of communication of the individual or, as appropriate, the individual's representative.
- 5. The IPE shall be reviewed at least annually by a DBVI vocational rehabilitation counselor and the eligible individual or, as appropriate, the individual's representative to assess the eligible individual's progress in achieving the identified employment outcome.
- 6. The IPE shall be amended, as necessary, by the individual or, as appropriate, the individual's representative, in collaboration with a DBVI vocational rehabilitation counselor (to the extent determined to be appropriate by the individual) if there are substantive changes in the employment outcome, the vocational rehabilitation services to be provided, or the providers of the vocational rehabilitation services.
- 7. Amendments to the IPE shall not take effect until agreed to and signed by the individual or, as appropriate, the individual's representative and by a DBVI vocational rehabilitation counselor.
- 8. The IPE for a student with a disability who is receiving special education services shall be developed:
 - a. In consideration of the student's individualized education plan; and
 - b. In accordance with the plans, policies, procedures, and terms of the interagency agreement between DBVI and the Virginia Department of Education designed to facilitate the transition of students who are blind or vision impaired from school to the receipt of vocational rehabilitation services.
- 9. Content of the IPE. Each IPE shall include:
 - a. A description of the specific employment outcome chosen by the eligible individual that is:
 - (1) Consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, career interests, and informed choice; and
 - (2) To the maximum extent appropriate, results in employment in an integrated setting.
 - b. A description of the specific vocational rehabilitation services under 22VAC45-51-70 that are:
 - (1) Needed to achieve the employment outcome, including, as appropriate, the provision of assistive technology devices, assistive technology services, and personal assistance services, including training and management of those services; and
 - (2) Provided in the most integrated setting that is appropriate for the vocational rehabilitation services

- involved and is consistent with the informed choice of the eligible individual.
 - c. Timelines for the achievement of the employment outcome and for the initiation of vocational rehabilitation services.
 - d. A description of the entity or entities chosen by the eligible individual or, as appropriate, the individual's representative that shall provide the vocational rehabilitation services and the methods used to procure those vocational rehabilitation services.
 - e. A description of the criteria used to evaluate progress toward achievement of the employment outcome.
 - f. The terms and conditions of the IPE, including, as appropriate, information describing:
 - (1) The responsibilities of DBVI;
 - (2) The responsibilities of the eligible individual, including:
 - (a) The responsibilities the individual shall assume in relation to achieving the employment outcome;
 - (b) If applicable, the extent of the individual's participation in paying for the cost of vocational rehabilitation services; and
 - (c) The responsibility of the individual with regard to applying for and securing comparable services and benefits as defined in 22VAC45-51-10; and
 - (3) The services received by the individual from other comparable services and benefits as defined in 22VAC45-51-10.
 - 10. Post-employment services. The IPE for each individual shall contain, as determined to be necessary, statements concerning:
 - a. The expected need for post-employment services prior to closing the record of vocational rehabilitation services of an individual who has achieved an employment outcome;
 - b. A description of the terms and conditions for the provision of any post-employment service; and
 - c. If appropriate, a statement of how post-employment services shall be provided or arranged through other comparable services and benefits as defined in 22VAC45-51-10.
- 22VAC45-51-90. Provision of services for individuals who are blind or visually impaired.**
- The provision of vocational rehabilitation services shall be based on the rehabilitation needs of each individual as identified in that individual's IPE and shall be consistent with the individual's informed choice. DBVI shall not place arbitrary limits on the nature and scope of vocational rehabilitation services to be provided to the individual to achieve an employment outcome:

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1. In-state vocational rehabilitation services shall be preferred provided that the preference does not effectively deny an individual a necessary vocational rehabilitation service. If the individual chooses an out-of-state vocational rehabilitation service at a higher cost than an in-state vocational rehabilitation service and if either vocational rehabilitation service would meet the individual's rehabilitation needs, DBVI shall not be responsible for those costs in excess of the cost of the in-state vocational rehabilitation service.

2. DBVI shall maintain written policies governing the rates of payment for all purchased vocational rehabilitation services.

3. DBVI shall maintain a fee schedule designed to ensure a reasonable cost to the program for each vocational rehabilitation service that is not so low as to effectively deny an individual a necessary vocational rehabilitation service and not absolute and permits exceptions so that individual needs can be addressed.

4. DBVI shall not place absolute dollar limits on specific vocational rehabilitation service categories or on the total vocational rehabilitation services provided to an individual.

5. DBVI shall not establish absolute time limits on the provision of specific vocational rehabilitation services or on the provision of vocational rehabilitation services to an individual. The duration of each vocational rehabilitation service needed by an individual shall be determined on an individual basis and reflected in that individual's IPE.

6. DBVI shall authorize vocational rehabilitation services in a timely manner.

7. Written authorizations shall be made either before or at the same time as the purchase of vocational rehabilitation services. An oral authorization may be given in an emergency situation, and the nature of the emergency, the specific authorization given, and the manner in which the authorization was made shall be documented in the individual's case file, and the authorization shall be confirmed in writing and forwarded to the provider of vocational rehabilitation services.

22VAC45-51-100. Participation of individuals in the cost of services based on financial need.

A. Individuals shall be required to participate in the costs of vocational rehabilitation services listed in subsection F of this section provided by DBVI based on financial need. DBVI shall consider certain factors in order to determine the financial needs of individuals applying for and receiving DBVI vocational rehabilitation services.

B. DBVI shall consider an individual's financial need based on certain allowances and exclusions including:

1. The individual's gross income. DBVI shall use a uniform income level including normal living requirements based on the median income for a four-person family provided by the Bureau of the Census as published in the Federal

Register (45 CFR 96.85) for the Low Income Home Energy Assistance Program (LIHEAP). The individual's financial need shall be based on 100% of the federal estimated median income in Virginia, which is published annually in the Federal Register;

2. The individual's income or a portion of the individual's income based on family size;

3. The estimated cost of the individual's vocational rehabilitation services specifically related to the individual's disability and not covered by comparable services and benefits; and

4. The tuition costs for the individual or a family member to attend a private or public educational facility.

C. DBVI shall consider the financial needs of eligible individuals using the following income:

1. Annual taxable income (gross income);

2. Annual nontaxable income such as social security benefits, veterans' benefits, retirement benefits, and workers' compensation benefits;

3. Total cash assets, including checking and savings accounts, certificates, stocks, and bonds. DBVI shall maintain Exemptions for Liquid Assets table; and

4. Income from real property.

D. Annually, DBVI shall make a determination of the financial contribution of the individual resulting from an examination of (i) the number of persons in the family unit; (ii) annual taxable income minus allowances; and (iii) exclusions based on individual costs for medical or educational services specifically related to the individual's disability.

E. Individuals with disabilities receiving social security benefits under Title II or XVI of the Social Security Act are exempt from consideration of financial need for vocational rehabilitation services.

F. DBVI shall consider the financial need of eligible individuals who receive the following vocational rehabilitation services:

1. Tuition for college or other training;

2. Medical treatment and physical restoration services;

3. Books and supplies;

4. Services to members of an eligible individual's family when necessary to the vocational rehabilitation of the eligible individual;

5. Occupational licenses, tools, equipment, and initial stock and supplies;

6. Maintenance, as defined in 22VAC45-51-10, during training;

7. Personal incidentals during training;

8. Telecommunications, sensory, and other technological aids and devices when such aids and equipment are not

used as adaptive devices for vocational training or employment or both;

9. Transportation; and

10. Rehabilitation engineering services when not incidental to the evaluation of rehabilitation potential.

22VAC45-51-110. Participation of individuals in use of comparable services and benefits.

A. Prior to providing any vocational rehabilitation services to an eligible individual, or to members of the individual's family, DBVI shall determine whether comparable services and benefits, as defined in 22VAC45-51-10, exist under any other program and whether those services and benefits are available to the individual unless such a determination would interrupt or delay the following:

1. The progress of the individual toward achieving the employment outcome identified in the IPE;
2. An immediate job placement; or
3. The provision of vocational rehabilitation services to any individual who is determined to be at extreme medical risk, based on medical evidence provided by an appropriate qualified medical professional.

B. The following vocational rehabilitation services shall be exempt from a determination of the availability of comparable services and benefits and financial need consideration:

1. Assessment for determination of eligibility and vocational rehabilitation needs and priority of vocational rehabilitation services;
2. Counseling and guidance, including information and support services to assist an individual in exercising informed choice;
3. Referral and other services to secure needed services from other agencies;
4. Job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services;
5. Post-employment services consisting of services listed under subdivisions 1 through 4 of this subsection;
6. Reader service for eligible individuals enrolled in college or in a vocational training program;
7. Adjustment training and evaluations provided at the Virginia Rehabilitation Center for the Blind and Vision Impaired in Richmond;
8. Prevocational adjustment training, such as rehabilitation teaching, provided to eligible individuals receiving vocational rehabilitation services from DBVI staff;
9. Interpreter services for eligible individuals who are deafblind;
10. Orientation and mobility training;
11. Summer work experience for high school and college students;

12. Work evaluation up to 30 days;

13. Community evaluation training program with rehabilitation teaching;

14. Work experience for adults up to three months;

15. Work adjustment training up to three months;

16. On-the-job training up to 30 days;

17. Supported employment services; and

18. Personal assistance services.

C. If comparable services and benefits exist under any other program and are available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual's IPE, DBVI shall use those comparable services and benefits to meet, in whole or part, the costs of the vocational rehabilitation services.

D. If comparable services and benefits exist under any other program, but are not available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual's IPE, DBVI shall provide vocational rehabilitation services until those comparable services and benefits become available.

22VAC45-51-120. Periodic review of ineligibility determinations.

When DBVI determines that an applicant is ineligible for vocational rehabilitation services or determines that an individual receiving vocational rehabilitation services under an IPE is no longer eligible for vocational rehabilitation services, DBVI shall:

1. Make a determination of ineligibility only after providing the individual, or as appropriate, the individual's representative, with an opportunity for full consultation;
2. Inform the individual in writing, supplemented as necessary by other modes of communication consistent with the informed choice of the individual, of the ineligibility determination including reasons for that determination;
3. Inform the individual in writing, supplemented as necessary by other modes of communication consistent with the informed choice of the individual, the means by which the individual may express and seek remedy for dissatisfaction, including the procedures for review of determinations by DBVI;
4. Provide the individual with a description of services available from the client assistance program established in the disAbility Law Center of Virginia; and
5. Within 12 months of the ineligibility determination and annually thereafter if requested by the individual or, if appropriate, by the individual's representative, review any ineligibility determination that is based on a finding that the individual is incapable of achieving an employment outcome. This review need not be conducted in situations in which the individual has refused it, the individual is no longer present in the state, the individual's whereabouts are

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unknown, or the individual's medical condition is rapidly progressive or terminal.

22VAC45-51-130. Periodic review of extended employment.

DBVI shall annually review and reevaluate the status of each individual with a disability who has achieved an employment outcome either in an extended employment setting in a community rehabilitation program or in any other employment setting in which the individual is compensated in accordance with § 14(c) of the Fair Labor Standards Act and 29 CFR Part 525 for two years after the individual achieves the employment outcome (and thereafter if requested by the individual or, if appropriate, the individual's representative) to determine the interests, priorities, and needs of the individual with respect to competitive employment or training for competitive employment.

22VAC45-51-140. Review of determinations made by DBVI.

A. An applicant or eligible individual who is dissatisfied with any determination made by DBVI that affects the provision of vocational rehabilitation services may request, or, if appropriate, may request through the individual's representative, a timely review of that determination.

B. General requirements.

1. Notification. DBVI shall provide the applicant, or eligible individual or, as appropriate, the individual's representative, notice of:

- a. His right to obtain review of DBVI determinations that affect the provision of vocational rehabilitation through an impartial due process hearing conducted by an impartial hearing officer;
- b. His right to informal dispute resolution;
- c. His right to pursue mediation with respect to determinations made by DBVI that affect the provision of vocational rehabilitation services to the applicant or eligible individual conducted by an impartial certified mediator;
- d. The names and addresses of individuals with whom requests for mediation or due process hearings may be filed;
- e. The manner in which a mediator or impartial hearing officer may be selected; and
- f. The availability of the client assistance program, established in the disAbility Law Center of Virginia, to assist the applicant or eligible individual during mediation sessions or impartial due process hearings.

2. Timing. DBVI shall provide notice of the review process:

- a. At the time the individual applies for vocational rehabilitation services;
- b. At the time the individual is assigned to a category in DBVI's order of selection;

c. At the time the IPE is developed; and

d. Whenever vocational rehabilitation services for an individual are reduced, suspended, or terminated.

3. DBVI shall not suspend, reduce, or terminate vocational rehabilitation services provided to an applicant or eligible individual, including evaluation and assessment services and IPE development, pending a decision by a hearing officer, mediator, or informal resolution unless:

a. The individual or, in appropriate cases, the individual's representative, requests a suspension, reduction, or termination of services; or

b. DBVI has evidence that the services have been obtained through misrepresentation, fraud, collusion, or criminal conduct on the part of the individual or the individual's representative.

C. Informal dispute resolution.

1. DBVI maintains a two-step informal dispute resolution process that is available, at a minimum, whenever an applicant or eligible individual or, as appropriate, the individual's representative, requests an impartial due process hearing under this section.

a. Step 1. If an individual has a complaint or grievance that cannot be resolved in conversation with the DBVI employee, the individual must prepare a written grievance on a grievance form obtainable from DBVI. The grievance form is submitted by the individual to the DBVI employee and the employee's supervisor. The supervisor shall meet with the individual, and as requested, the individual's representative, within a reasonable time not to exceed two weeks of DBVI's receipt of the grievance form. The supervisor shall work with the individual to reach a mutually satisfactory solution to the grievance.

b. Step 2. If the individual's grievance is not resolved in Step 1, the individual may request a meeting with the Deputy Commissioner of DBVI. This request shall be made in writing to the deputy commissioner within two weeks of the Step 1 decision. The deputy commissioner shall meet with the individual and, as requested, the individual's representative within five full working days of receipt of the Step 2 request. The deputy commissioner shall reply in writing to the individual within three full working days following the Step 2 meeting. In the event that the individual's complaint involves the supervisor, the deputy commissioner shall handle the Step 1 meeting, and the commissioner shall handle the Step 2 meeting.

c. Steps 1 and 2 may be conducted in person or by telephone.

2. Participation in the informal dispute resolution process shall be voluntary on the part of the applicant or eligible individual and on the part of DBVI.

3. The informal dispute resolution process shall not be used to deny the right of an applicant or eligible individual to a hearing, including the right to pursue mediation.

4. If informal dispute resolution is not successful in resolving the dispute, a formal hearing shall be conducted within 60 days of the applicant's or eligible individual's request for review of a determination made by DBVI, unless DBVI and the individual agree to a specific extension of time.

D. Mediation.

1. A mediation process shall be made available, at a minimum, whenever an applicant or eligible individual or, as appropriate, the individual's representative requests an impartial due process hearing under this section.

2. Participation in the mediation process shall be voluntary on the part of the applicant or eligible individual and on the part of DBVI.

3. Use of the mediation process shall not be used to deny or delay the applicant's or eligible individual's right to pursue resolution of the dispute through an impartial hearing held within the time period specified in subsection E of this section.

4. The mediation process shall be conducted by a qualified and impartial mediator who shall be selected from a list of qualified and impartial mediators maintained by DBVI.

5. At any point during the mediation process, either party or the mediator may elect to terminate the mediation. In the event mediation is terminated, either party may pursue resolution through an impartial hearing.

6. The applicant or eligible individual or, as appropriate, the individual's representative shall have the opportunity to submit during mediation sessions or due process hearings evidence and other information that supports the applicant's or eligible individual's position.

7. The applicant or eligible individual may be represented during mediation sessions or due process hearings by counsel or other advocates selected by the applicant or eligible individual.

E. Formal due process hearings.

1. If the individual is not satisfied with decisions made during the informal resolution process or through mediation, he may proceed to a formal due process hearing by making a request in writing to the DBVI Vocational Rehabilitation Director.

2. The formal due process hearing shall be conducted by an impartial hearing officer within 60 days of the applicant's or eligible individual's request for review of a determination made by DBVI unless informal resolution or a mediation agreement achieves resolution prior to the 60th day or the parties agree to a specific extension of time.

3. DBVI shall randomly select the impartial hearing officer from a list of qualified hearing officers identified jointly by

the State Rehabilitation Council for the Blind and Vision Impaired and the Department for Aging and Rehabilitative Services.

4. The hearing officer shall conduct the formal due process hearing in accordance with this section and federal vocational rehabilitation regulations.

5. In addition to the rights described in this section, the applicant or eligible individual or, if appropriate, the individual's representative shall be given the opportunity to present witnesses during the hearing and to examine all witnesses and other relevant sources of information and evidence.

6. The applicant or eligible individual or, as appropriate, the individual's representative shall have the opportunity to submit during the formal due process hearings evidence and other information that supports the applicant's or eligible individual's position.

7. The applicant or eligible individual may be represented during the formal due process hearings by counsel or other advocates selected by the applicant or eligible individual.

8. Conduct of the formal due process hearing:

a. The hearing officer shall determine the propriety of attendance at the hearing of those individuals not having a direct interest in the hearing.

b. The hearing officer may, at the beginning of the hearing, ask for statements clarifying the issues involved.

c. Exhibits offered by the applicant or eligible individual may be received by the hearing officer; when received, the exhibits shall be marked and made part of the record.

d. The applicant or eligible individual and his representative and the DBVI employee shall then present claims, proof, and witnesses who shall submit to questions or other examinations. The hearing officer, at his discretion, may vary this procedure but shall present full opportunity to all parties and witnesses for presentation of any material or relevant proof.

e. The parties shall produce such additional evidence as the hearing officer may deem necessary to reach an understanding or determination of the dispute. The hearing officer shall be the judge of relevancy or materiality of the evidence presented in the case. All evidence shall be taken in the presence of the parties.

f. After all evidence has been presented, the hearing officer shall declare the hearing closed.

9. At the conclusion of the formal hearing, the hearing officer shall issue a written decision of his findings of fact and conclusions of law within 30 days of the completion of the formal hearing.

10. The hearing officer's decision shall be a final decision, and the applicant or eligible individual may appeal the hearing officer's decision to a representative from the

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Governor's office within 20 days of the mailing of the impartial hearing officer's decision.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (22VAC45-51)

[Application for Vocational Rehabilitation Services, DBVI-04-01 \(rev. 4/2014\)](#)

[Consent to Release Confidential Information for Alcohol or Drug Patients, DBVI-70-22 \(rev. 10/2015\)](#)

[Consent to Release Health Information, DBVI-70-23 \(rev. 10/2015\)](#)

[Consent to Release Personal Information, DBVI-70-29 \(rev. 10/2015\)](#)

[Eye Exam Report, DBVI-70-20E \(rev. 7/2014\)](#)

[Financial Determination/Redetermination Statement Form, DBVI-70-06 \(rev. 9/2014\)](#)

[Health Checklist/General Medical Examination, DBVI-70-04 \(rev. 6/2014\)](#)

[Individualized Plan for Employment Form \(eff. 12/2015\)](#)

[Individualized Plan for Employment Planned Services Form \(rev. 12/2015\)](#)

[Service Complaint/Grievance Form, DBVI-70-01 \(rev. 9/2013\)](#)

V.A.R. Doc. No. R09-1168; Filed August 24, 2016, 12:22 p.m.

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DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

2016 Annual Report - Agricultural Stewardship Act

The Commissioner of Agriculture and Consumer Services announces the availability of the annual report of the Agricultural Stewardship Act entitled "Agricultural Stewardship Act Annual Report, April 1, 2015 – March 31, 2016." Copies of this report can be obtained by contacting Joyce Knight at telephone, (804) 786-3538 or via email at joyce.knight@vdacs.virginia.gov. The report can also be obtained by accessing the Virginia Department of Agriculture and Consumer Services website at <http://www.vdacs.virginia.gov/conservation-and-environmental-agricultural-stewardship.shtml>. A written request may be sent to the address below. Copies of the report are available without charge.

Department of Agriculture and Consumer Services
Office of Policy, Planning, and Research
P. O. Box 1163
Richmond, VA 23218

Questions regarding the report may be directed to the contact listed above.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Civil Enforcement Manual

Purpose of notice: To announce an opportunity for public comment on the Department of Environmental Quality's Civil Enforcement Manual.

Revised public comment period: August 22, 2016, through October 21, 2016

Topic of public comment: The Department of Environmental Quality (DEQ) is providing an opportunity for the public to comment on draft, revised guidance used in its enforcement program. The draft, revised guidance addresses the procedures that DEQ staff use to resolve and prioritize alleged violations of environmental requirements and how to calculate appropriate civil charges and civil penalties in administrative enforcement actions for DEQ's air stationary source program, land protection and remediation programs, and water programs. Once final, the draft, revised guidance will supersede the current Chapters 2 through 4 of the DEQ Civil Enforcement Manual (Virginia Regulatory Town Hall ID: CEM-03, CEM-04, CEM-06, CEM-07, CEM-07A, and CEM-07B Memo).

The draft text can be found at <http://www.deq.virginia.gov/Programs/Enforcement/PublicNotices.aspx>. Comments can be emailed to Lee Crowell at lee.crowell@deq.virginia.gov.

Proposed Environmental Remedy for Internet Archer Creek Foundry

Date of this notice: September 18, 2016

Purpose of this notice: The Virginia Department of Environmental Quality (DEQ) is announcing its proposed remedy for the Internet Archer Creek Foundry located in Lynchburg, Virginia, under the Resource Conservation and Recovery Act (RCRA), as amended, 42 USC §§ 6901 through 6939(e). DEQ's proposed remedy consists of implementation and maintenance of institutional controls and engineering controls to protect human health and the environment.

Facility description: The 193-acre facility was a small castings foundry that manufactured metal parts for automobiles, heavy trucks, small internal combustion engines, computers, industrial tools, and household appliances. The facility (also known as Archer Creek Foundry) was owned by Internet Corporation from 1973 to 2009 when operations ceased, then sold to Virginia Casting Industries in 2010. The facility managed hazardous and nonhazardous wastes and completed numerous cleanup activities since 1998. Currently, the property consists of large concrete pads delineating the footprint of former structures, several derelict structures, a closed solid waste landfill, and elements of a former wastewater treatment system.

Information availability: A statement of basis for the proposed remedy is available on DEQ's website at <http://www.deq.virginia.gov/Programs/LandProtectionRevitalization/PublicNotices.aspx>.

The Administrative Record, which contains information considered in DEQ's proposed remedy, is available for public review at Virginia Department of Environmental Quality Central Office, 629 East Main Street, Richmond, VA 23219, during office hours, Monday through Friday, 8 a.m. to 5 p.m. For additional information, contact Brett Fisher, Corrective Action Project Manager, at the address listed above; telephone (804) 698-4219, FAX (804) 698-4234, or email brett.fisher@deq.virginia.gov.

Comment process: Persons wishing to comment on DEQ's proposed remedy must submit comments to DEQ within the 30-day comment period ending October 18, 2016. Interested persons may also request a public meeting on this proposed remedy. All comments or requests for a meeting must be submitted in writing via mail, fax, or email to the DEQ project manager, Brett Fisher, as listed above, and must be received prior to October 18, 2016. All comments will be considered in making a final decision.

Final decision: DEQ will make a final decision after considering all comments, consistent with applicable RCRA requirements and regulations. If the decision is substantially unchanged from the one in this notice, DEQ will issue a final

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decision and inform all persons who submitted written comments or requested notice of DEQ's final determination. If the final decision is significantly different from the one proposed, DEQ will issue a public notice explaining the new decision and will reopen the comment period.

STATE BOARD OF HEALTH

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Health is conducting a periodic review and small business impact review of **12VAC5-630, Private Well Regulations**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins September 19, 2016, and ends October 10, 2016.

Comments may be submitted online to the Virginia Regulatory Town Hall at <http://www.townhall.virginia.gov/L/Forums.cfm>. Comments may also be sent to Dwayne Roadcap, Division Director, Onsite Sewage, Water Services, Environmental Engineering and Marina Programs, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7058, FAX (804) 864-7475, or email dwayne.roadcap@vdh.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Draft Provider Access Monitoring Plan

Notice is hereby given that the Department of Medical Assistance Services (DMAS) is publishing for public comment the agency's Draft Provider Access Monitoring Plan

as required by the Final Provider Access Monitoring Rule found in 42 CFR 447.203.

Comments or inquiries may be submitted through September 29, 2016, in writing, to Brian McCormick at email brian.mccormick@dmas.virginia.gov. Comments are available for review at <http://townhall.virginia.gov/L/comments.cfm?GeneralNoticeid=628>. The full text of the report may be found at the top of the "What's New" section on the right hand side of the DMAS website at <http://www.dmas.virginia.gov>.

Virginia Access Monitoring Review Plan Overview

In November 2015, the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding member access to Medicaid services in a Medicaid fee-for-service (FFS) environment. This rule creates new requirements for states to monitor access to care for Medicaid FFS members. Under these requirements, states must develop an access monitoring review plan, which must be published for public review and comment and submitted to CMS. In accordance with these requirements, the Virginia DMAS has prepared the access monitoring review plan.

The Virginia Medicaid program provides health care coverage for low-income individuals, including children, pregnant women, individuals with disabilities, the elderly, parents, and other adults. DMAS is the single state agency that administers the Medicaid program in the Commonwealth of Virginia. The mission of the Virginia Medicaid program is to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.

DMAS provides Medicaid coverage to individuals through managed care and fee-for-service delivery models. The managed care delivery system, known as Medallion 3.0., covers Medicaid members through six commercial health plans. Virginia has been increasing its use of the managed care program, and as of December 2015, over 68% of Medicaid enrollees are in managed care. During state fiscal year (SFY) 2015, the Virginia Medicaid program provided coverage to approximately 1.35 million enrolled members, and total Medicaid spending was approximately \$7.9 billion.

Virginia has a population of 8.4 million people, making it the 12th most populous state in the United States. With 98 acute care hospitals and affiliated practices and a network of 130 federally qualified health center and rural health clinic sites, there are numerous options for Medicaid members to receive health care services.

Virginia is committed to ensuring its enrolled members have adequate access to health care services. A key component of DMAS' strategic plan is ensuring adequate provider network access by monitoring and analyzing utilization, provider caseloads, reimbursement rates, and Medicaid population groups. The state has conducted other studies on member

access to health care services, including a 2013 study by the Joint Legislative Audit and Review Commission, and on health care access to ensure that its Medicaid FFS members have access to care that is comparable to the general population. The methodology employed in this plan will consist of evaluating trends in provider availability and participation in the Medicaid program, trends in utilization of services by Medicaid members, and member and provider feedback.

Using the metrics and data sources described in this plan, DMAS will measure and monitor indicators of health care access to ensure that its Medicaid FFS members have access to care that is comparable to the general population. The methodology employed in this plan will consist of evaluating trends in provider availability and participation in the Medicaid program, trends in utilization of services by Medicaid members, and member and provider feedback. Through the FFS monitoring plan and subsequent updates to the plan, DMAS anticipates that the access monitoring analysis, metrics, data sources, and other factors will evolve over time. Separate access monitoring and provider network sufficiency requirements are present in a managed care environment and under home and community-based services waiver programs, and these issues are not addressed in this plan.

Because members located in different areas may have different experiences accessing health care services, this plan will analyze access to care by geographic region. Specifically, the plan will analyze access to care for the regions utilized by the Virginia Medicaid program for Managed Long-term Supports and Services and the managed care program, Medallion 3.0.

In accordance with 42 CFR 447.203, Virginia developed this access monitoring review plan for the following service categories provided under a FFS arrangement:

- Primary care services
- Physician specialist services
- Behavioral health services
- Pre-natal and post-natal obstetric services, including labor and delivery
- Home health services

The plan describes data that will be used to measure access to care for members in FFS. The plan considers the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid members' health care needs are fully met. The plan was developed during the months of July and August 2016 and posted on the Virginia Regulatory Town Hall website under General Notices, found at the following address: <http://townhall.virginia.gov/L/EditNotice.cfm?GNid=new> from August 28, 2016, to September 29, 2016, as well as

posted on the DMAS website at <http://www.dmas.virginia.gov> to allow for public inspection and feedback.

Contact Information: Emily McClellan, Regulatory Manager, Division of Policy and Research, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, TDD (800) 343-0634, or email emily.mcclellan@dmas.virginia.gov.

Notice of Intent to Change the Reimbursement Methodology for Pharmacy Services

Notice is hereby given that the Department of Medical Assistance Services (DMAS) intends to change the reimbursement methodology for pharmacy services pursuant to the department's authority under Title XIX of the *Social Security Act*. This notice is intended to satisfy the requirements of 42 CFR 447.205 and of § 1902(a)(13) of the *Social Security Act*, 42 USC § 1396a(a)(13).

A copy of this notice is available for public review from Donna Proffitt, Manager, Pharmacy Services, Division of Health Care Services, Department of Medical Assistance Services, 600 Broad Street, Suite 1300, Richmond, VA 23219.

DMAS is specifically soliciting input from stakeholders, providers, and beneficiaries on the potential impact of the proposed reimbursement adjustments to pharmacy services. Comments or inquiries may be submitted, in writing, through September 29, 2016, to Ms. Proffitt at donna.proffitt@dmas.virginia.gov, and such comments are available for review at <http://townhall.virginia.gov/L/ViewNotice.cfm?gnid=623>. Comments may also be submitted, in writing, on the Regulatory Town Hall public comment forum at <http://townhall.virginia.gov>.

This notice is available for public review on the Regulatory Town Hall, on the General Notices page at <http://townhall.virginia.gov/L/generalnotice.cfm>.

DMAS is making these changes in its methods and standards for setting payment rates for services in order to comply with the legislative mandates set forth in Item 306 of Chapter 780 of the 2016 Acts of Assembly.

In order to comply with a new requirements in a final federal rule entitled "Medicaid Program; Covered Outpatient Drugs" that was published in the Federal Register on February 1, 2016, DMAS proposes the following new payment methodology for pharmacy services effective December 1, 2016:

A. Payment for covered outpatient legend and nonlegend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a \$10.65 professional dispensing. The drug ingredient cost reimbursement shall be the lowest of:

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- 1) The national average drug acquisition cost (NADAC) of the drug;
- 2) When no NADAC is available, DMAS shall reimburse at wholesale acquisition cost (WAC) + 0%; or
- 3) The federal upper limit (FUL); or
- 4) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

B. Payment for specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail will include the drug ingredient cost plus a \$10.65 professional dispensing. The drug ingredient cost reimbursement shall be the lowest of:

- 1) The national average drug acquisition cost (NADAC) of the drug;
- 2) When no NADAC is available, DMAS shall reimburse at wholesale acquisition cost (WAC) + 0%; or
- 3) The federal upper limit (FUL); or
- 4) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

C. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a \$10.65 professional dispensing. The drug ingredient cost reimbursement shall be the lowest of:

- 1) The national average drug acquisition cost (NADAC) of the drug;
- 2) When no NADAC is available, DMAS shall reimburse at wholesale acquisition cost (WAC) + 0%; or
- 3) The federal upper limit (FUL); or
- 4) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

D. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and centers of excellence will include the drug ingredient cost plus a \$10.65 professional dispensing. The drug ingredient cost reimbursement shall be the lowest of:

- 1) The national average drug acquisition cost (NADAC) of the drug;
- 2) When no NADAC is available, DMAS shall reimburse at wholesale acquisition cost (WAC) + 0%; or
- 3) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

E. (1) 340B covered entities and federally qualified health centers (FQHCs) that fill Medicaid member prescriptions with drugs purchased at the prices authorized under § 340B of the Public Health Services Act will be reimbursed no more

than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee. Section 340B-covered entities that fill Medicaid member prescriptions with drugs not purchased under the § 340B of the Public Health Services Act will be reimbursed in accordance to § 7.1 plus the \$10.65 professional dispensing fee as described in § 7.8.

(2) Drugs acquired through the federal § 340B drug price program and dispensed by § 340B contract pharmacies are not covered.

F. Facilities purchasing drugs through the federal supply scheduled (FSS) or drug pricing program under 38 USC § 1826, 42 USC § 256b, or 42 USC § 1396-8, other than the § 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee. Nominal price as defined in 42 CFR 447.502 means a price that is less than 10% of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

G. Payment for pharmacy services will be as described in §§ 7.1 - 7.7; however, payment shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR 447.502, per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The professional dispensing fee for all covered outpatient drugs shall be \$10.65. The professional dispensing fee shall be determined by a cost of dispensing survey conducted at least every five years.

H. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106% of the average sales price (ASP). PADs without an ASP on the Centers for Medicare and Medicaid Services reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under § 340 B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

I. Payment dispensed to Indian Health Service, tribal, and urban Indian pharmacies. DMAS does not have any Indian Health Service, tribal, or urban Indian pharmacies enrolled at this time. Payment for pharmacy services will be defined in a state plan amendment if such entity enrolls with DMAS.

J. Investigational drugs are not a covered service under the DMAS pharmacy program.

Contact Information: Emily McClellan, Regulatory Manager, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, TDD (800) 343-0634, or email emily.mcclellan@dmas.virginia.gov.

STATE WATER CONTROL BOARD

Proposed Consent Special Order for Crossroads Holdings, LLC

An enforcement action has been proposed for Crossroads Holdings, LLC for violations at Crossroads Quicklane in Prince George, Virginia. The State Water Control Board proposes to issue a special order by consent to Crossroads Holdings, LLC to address noncompliance with the State Water Control Law and regulations. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Carla Pool will accept comments by email at carla.pool@deq.virginia.gov, FAX at (804) 698-4277, or postal mail at Department of Environmental Quality, Central Office, P.O. Box 1105, Richmond, VA 23218, from September 19, 2016, to October 19, 2016.

Total Maximum Daily Load for Woods Creek

Committee meeting: A community meeting will be held Wednesday, October 5, 2016, at 6:30 p.m. at Maury River Middle School. This meeting will be open to the public and all are welcome. In the case of inclement weather, the meeting will be postponed until Tuesday, October 11, 2016, at 6:30 p.m. For more information, please contact Tara Sieber at email tara.sieber@deq.virginia.gov or telephone at (540) 574-7870.

Purpose of notice: The Department of Environmental Quality (DEQ) and its contractor, Virginia Tech's Biological Systems Engineering Department, will discuss population data for the development of a water quality study known as a total maximum daily load (TMDL) for Woods Creek. This is an opportunity for local residents to learn about the condition of this stream, share information about the area, and become involved in the process of local water quality improvement. A public comment period will follow the meeting (October 5, 2016, through November 7, 2016).

Meeting description: A public meeting will be held to introduce to the local community the water quality improvement process in Virginia, known as the TMDL process, invite their participation and solicit their contributions, showcase the water quality studies done by local school students, and review next steps. Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report.

Description of study: Woods Creek does not meet water quality standards for recreation due to an excess of bacteria. In addition, this stream does not host a healthy and diverse population of aquatic life and subsequently was listed as impaired for the "General Benthic (Aquatic life)" water quality standards. The bacteria standard preserves the "Primary Contact (recreational or swimming)" designated use

for Virginia waterways. Excessive bacteria levels may pose a threat to human health. This water quality study reports on the sources of bacterial contamination and recommends reductions to meet TMDLs for the impaired waters. A TMDL is the total amount of a pollutant a water body can contain and still meet water quality standards. To restore water quality, bacterial levels need to be reduced to the TMDL amount. Virginia agencies are working to identify sources of bacteria and will determine the pollutant cause of the benthic impairments as well as identify sources of this pollutant through a weight of evidence approach. Reductions and a TMDL for the cause of the impairment will be developed.

Stream	County	Impairment
Woods Creek	Lexington and Rockbridge County	Bacteria, Aquatic Life

How to comment and participate: The meetings of the TMDL process are open to the public, and all interested parties are welcome. Written comments will be accepted through November 7, 2016, and should include the name, address, and telephone number of the person submitting the comments. For more information or to submit written comments, please contact Tara Sieber, Department of Environmental Quality, Valley Regional Office, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7870, FAX (540) 574-7878, or email tara.sieber@deq.virginia.gov.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, General Assembly Building, 201 North 9th Street, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; *Email:* varegs@dls.virginia.gov.

Meeting Notices: Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at <http://www.virginia.gov/connect/commonwealth-calendar>.

Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed: A table listing regulation sections that have been amended, added, or repealed in the *Virginia Register of Regulations* since the regulations were originally published or last supplemented in the print version of the Virginia Administrative Code is available at <http://register.dls.virginia.gov/documents/cumultab.pdf>.

Filing Material for Publication in the Virginia Register of Regulations: Agencies use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations*. The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.

General Notices/Errata

ERRATA

STATE BOARD OF HEALTH

Notice of Update to Internet Address in Virginia Administrative Code

Pursuant to 1VAC7-10-60, the Registrar of Regulations has updated an invalid Internet address in the Virginia Administrative Code as follows:

Title of Regulation: **12VAC5-195. Virginia WIC Program.**

Correction to 12VAC5-195-680 D:

At the end of 12VAC5-195-680 D, replace the Internet address with the following:

<http://www.vdh.virginia.gov/livewell/programs/wic/content/retailers/documents/UPCUpdateRequestForm.pdf>.

Contact Information: Susan Puglisi, Policy Analyst, Office of Family Health Services, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7175, or email susan.puglisi@vdh.virginia.gov.

BOARD OF HISTORIC RESOURCES

Title of Regulation: **17VAC5-20. Regulations Governing Permits for the Archaeological Removal of Human Remains.**

Publication: 32:25 VA.R. 3424-3428 August 8, 2016

Correction to Final Regulation:

Page 3424, column 1, Effective Date, change "September 20, 2016" to "September 8, 2016"

VA.R. Doc. No. R14-3990; Filed September 8, 2016, 8:58 a.m.