VIRGINIA
REGISTER OF REGULATIONS

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Virginia Code Commission **http://register.dls.virginia.gov**

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THE 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 12 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. **26:20 VA.R. 2510-2515 June 7, 2010,** refers to Volume 26, Issue 20, pages 2510 through 2515 of the *Virginia Register* issued on June 7, 2010.

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,** Chairman; **Bill Janis,** Vice Chairman; **James M. LeMunyon; Ryan T. McDougle; Robert L. Calhoun; Frank S. Ferguson; E.M. Miller, Jr.; Thomas M. Moncure, Jr.; Wesley G. Russell, Jr.; Charles S. Sharp; Robert L. Tavenner; Patricia L. West; J. Jasen Eige or Jeffrey S. Palmore.**

Staff of the *Virginia Register:* **Jane D. Chaffin,** Registrar of Regulations; **June T. Chandler,** Assistant Registrar.

PUBLICATION SCHEDULE AND DEADLINES

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

September 2011 through November 2012

Volume: Issue	Material Submitted By Noon*	Will Be Published On
28:2	September 7, 2011	September 26, 2011
28:3	September 21, 2011	October 10, 2011
28:4	October 5, 2011	October 24, 2011
28:5	October 19, 2011	November 7, 2011
28:6	November 2, 2011	November 21, 2011
28:7	November 15, 2011 **(Tuesday)**	December 5, 2011
28:8	November 30, 2011	December 19, 2011
28:9	December 13, 2011 **(Tuesday)**	January 2, 2012
28:10	December 27, 2011 **(Tuesday)**	January 16, 2012
28:11	January 11, 2012	January 30, 2012
28:12	January 25, 2012	February 13, 2012
28:13	February 8, 2012	February 27, 2012
28:14	February 22, 2012	March 12, 2012
28:15	March 7, 2012	March 26, 2012
28:16	March 21, 2012	April 9, 2012
28:17	April 4, 2012	April 23, 2012
28:18	April 18, 2012	May 7, 2012
28:19	May 2, 2012	May 21, 2012
28:20	May 16, 2012	June 4, 2012
28:21	May 30, 2012	June 18, 2012
28:22	June 13, 2012	July 2, 2012
28:23	June 27, 2012	July 16, 2012
28:24	July 11, 2012	July 30, 2012
28:25	July 25, 2012	August 13, 2012
28:26	August 8, 2012	August 27, 2012
29:1	August 22, 2012	September 10, 2012
29:2	September 5, 2012	September 24, 2012
29:3	September 19, 2012	October 8, 2012
29:4	October 3, 2012	October 22, 2012
29:5	October 17, 2012	November 5, 2012
29:6	October 31, 2012	November 19, 2012

*Filing deadlines are Wednesdays unless otherwise specified.

PETITIONS FOR RULEMAKING

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Initial Agency Notice

Title of Regulation: **12VAC5-590. Waterworks Regulations.**

Statutory Authority: § 32.1-170 of the Code of Virginia.

Name of Petitioner: G. M. Loupassi, Member, Virginia House of Delegates.

Nature of Petitioner's Request: The petitioner requests that the State Board of Health amend its regulations governing cross connection control and backflow prevention, contained in Virginia's Waterworks Regulations (12VAC5-590-580 et seq.). Currently, the regulations call for, in relevant part, annual inspections of backflow prevention devices on individual homeowners' lawn sprinkler systems. The petitioner suggests, in a letter to the commissioner, that a tiered system with lesser requirements for lower risk connections, such as individual homeowners' lawn sprinkler systems, might be in order, while also recognizing that "perhaps there are solutions that I am unaware of. . . ." The petitioner writes that "given the relatively low risk of contamination from such a source lawn sprinkler systems, combined with the onerous burden placed on homeowners with such systems, I respectfully ask that you review these regulations and consider a tiered system, with lesser requirements for lower risk connections."

Agency's Plan for Disposition of Request: Following a 21-day public comment period, the Virginia Department of Health will consider the petition in light of any comments or information received.

Public Comment Deadline: October 16, 2011.

Agency Contact: Robert A. K. Payne, Legal Affairs Manager, Department of Health, Office of Drinking Water, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7498, or email rob.payne@vdh.virginia.gov.

VA.R. Doc. No. R12-02; Filed August 31, 2011, 11:14 a.m.

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 8. EDUCATION

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

Final Regulation

REGISTRAR'S NOTICE: The State Council of Higher Education for Virginia is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 B 4 of the Code of Virginia, which exempts regulations relating to grants of state or federal funds or property.

Titles of Regulations: **8VAC40-70. Tuition Assistance Grant Program Regulations (repealing 8VAC40-70-10 through 8VAC40-70-60).**

8VAC40-71. Virginia Tuition Assistance Grant Program Regulations (adding 8VAC40-71-10 through 8VAC40-71-60).

Statutory Authority: § 23-38.13 of the Code of Virginia.

Effective Date: September 16, 2011.

Agency Contact: Linda H. Woodley, Regulatory Coordinator, State Council of Higher Education for Virginia, James Monroe Building, 101 North 14th Street, 9th Floor, Richmond, VA 23219, telephone (804) 371-2938, FAX (804) 786-2027, or email lindawoodley@schev.edu.

Summary:

Due to the extensive nature of the changes to the Tuition Assistance Grant Program Regulations, the current regulations (8VAC30-70) are repealed and new regulations (8VAC30-71) are promulgated. The regulations implement a grant program for students attending private nonprofit colleges and universities in Virginia. The regulations provide definitions; institutional application to participate procedures; disbursement of funds procedures; student eligibility criteria; amount of awards; and responsibilities of the council, participating institutions, and students.

Key changes between the existing and new regulations include amendments that (i) clarify and reorganize the regulations to improve flow and remove redundant language; (ii) respond to legislative changes enacted by the General Assembly; and (iii) describe how federal Chapter 33 veterans' tuition benefits interact with other forms of financial assistance.

CHAPTER 71
VIRGINIA TUITION ASSISTANCE GRANT PROGRAM REGULATIONS

8VAC40-71-10. Definitions.

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

"Academic year" means the enrollment period that normally extends from late August to May or early June and that is normally comprised of two semesters 15 to 16 weeks in length or three quarters 10 to 11 weeks in length.

"Accredited" means approved to confer degrees pursuant to the provisions of Chapter 21.1 (§ 23-276.1 et seq.) of Title 23 of the Code of Virginia and requirements of the annual appropriation act, as the same are now constituted or hereafter amended. Unless otherwise provided by law, an institution must be accredited by a nationally recognized regional accrediting agency prior to participation in the program.

"Award" means a grant of Virginia Tuition Assistance Grant Program funds given during fall and spring terms at semester institutions and fall, winter, and spring terms at quarter institutions.

"Census date" means the time during a term when a count of enrolled students is made for reporting purposes. For all standard terms, the census date shall be the end of the program add/drop period. For nonstandard terms, the census date shall be determined by council on a program by program basis.

"Cost of attendance" means the sum of tuition, fees, room, board, books, supplies, and other education-related expenses, as determined by an eligible institution for purposes of calculating a student's financial need and awarding federal student aid funds.

"Council" means the State Council of Higher Education for Virginia or its designated staff.

"Domiciliary resident" means a student who is determined by the enrolling institution to be a domiciliary resident of Virginia or deemed as domiciled as specified by § 23-7.4 of the Code of Virginia and the council's guidelines for domiciliary status determinations. In cases where there are disputes between students and the enrolling institutions, the council shall make the final determinations (see 8VAC40-71-40 E).

"Eligible institution" means private nonprofit institutions of collegiate education in the Commonwealth whose primary purpose is to provide collegiate, graduate, or professional education and not to provide religious training or theological education. Eligible institutions not admitted to this program before January 1, 2011, shall also:

1. Be formed, chartered, established, or incorporated within the Commonwealth;

2. Have their principal place of business within the Commonwealth;

3. Conduct their primary educational activity within the Commonwealth;

4. Be accredited by a nationally recognized regional accrediting agency; and

5. Comply with applicable reporting requirements as:

a. Found in the Code of Virginia or supporting administrative code for institutions operating in Virginia or participating in state financial aid programs; or

b. Identified by SCHEV as necessary for the administration of the program.

"Eligible program" means a curriculum of courses at the undergraduate, graduate, or first professional level for those institutions eligible under the definition of eligible institution. For those institutions chartered under an act of Congress and admitted to this program prior to January 1, 2011, only a curriculum of courses offered at a campus located in the Commonwealth are eligible programs.

1. Undergraduate programs are those programs that lead to an associate's or baccalaureate degree and that require at least two academic years (minimum 60 semester hours or its equivalent in quarter hours) to complete or an undergraduate teacher certification program.

2. Graduate programs are those programs leading to a degree higher in level than the baccalaureate degree and that require at least one academic year (minimum 30 semester hours or its equivalent in quarter hours) to complete. Only graduate programs in a health-related professional program, classified in the National Center for Education Statistics' Classification of Instructional Programs (CIP) Code 51-series programs are eligible graduate programs.

3. First-professional programs are those post-undergraduate programs leading to a degree in dentistry, medicine, veterinary medicine, or pharmacy. Only professional programs in a health-related professional program classified as CIP Code 51-series programs are eligible first-professional programs.

4. Programs that provide religious training or theological education, classified as CIP Code 39-series programs, are not eligible programs.

5. Students enrolled in a declared double-major that includes an ineligible degree program may receive an award only for those terms in which the student's enrollment includes an equal or greater number of courses required for an eligible major or concentration than the number of courses enrolled for an ineligible major or concentration (excludes general education or elective courses). Exceptions may be made by council based on circumstances beyond the control of the student.

"First-professional student" means a student enrolled and program placed in any of the following post-undergraduate programs: dentistry, medicine, veterinary medicine, or pharmacy.

"Fiscal year" means the period extending from July 1 to June 30.

"Formed, chartered, established, or incorporated within the Commonwealth" means the institution is, and continues to be, recognized as a domestic or in-state institution under SCHEV's certification to operate in Virginia and under state law.

"Full-time student" means a student who is enrolled for at least 12 credit hours per semester or its equivalent in quarter hours at the undergraduate level or nine credit hours per semester or its equivalent in quarter hours at the graduate or first-professional level. The total hours counted do not include courses taken for audit, but may include required developmental, remedial, or prerequisite courses and other elective for-credit courses that normally are not counted toward a degree at the institution. For students enrolled in:

1. Nonstandard terms: the full-time enrollment requirement, as approved by council, will be proportionate based on the length of the terms, the number of contact hours, or other measures of comparability with the institution's normal academic year.

2. Concurrent undergraduate, graduate, or first-professional courses: the full-time enrollment requirement may be met by a combination of the total credit hours, providing that the combination totals at least the minimum credit hours for full-time status, as described above, for the student's institutionally recognized student level.

3. Programs leading to a doctoral degree: the full-time enrollment requirement may be met by enrollment in nine credit hours per semester or its equivalent in quarter hours or the minimum full-time enrollment as defined by the institution, whichever is less.

"Graduate student" means a student enrolled and program-placed in a master's or doctoral program.

"Nonprofit institution" means an educational institution operated by one or more nonprofit corporations, and said institution's earnings are applied solely to the support of said institution and its educational programs and activities.

"Nonstandard degree program" means a degree program where the terms of the program do not conform to the standard terms of the institution's academic year. Nonstandard programs must be approved by council before students enrolled in the programs can receive awards.

"Participating eligible institution" means an eligible institution that has been approved to participate in the program by council.

"Principle place of business" means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the institution as a whole primarily exercise that function considering the following factors:

1. The state in which the primary executive and administrative offices of the institution are located. The primary executive and administrative offices are those most often physically used in the performance of the executive and administrative functions of the institution;

2. The state in which the principal office of the chief executive officer of the institution is located. The principal office of the chief executive officer is the location that is most often physically occupied by the chief executive officer when in performance of official institution duties;

3. The state in which the board of trustees or similar governing person or persons of the institution conducts a majority of its meetings; and

4. The state from which the overall operations of the institution are directed in that the institution is not subject to control or directives from an office, agency, or board located within another state.

"Program" means the Virginia Tuition Assistance Grant Program.

"Term" means the fall semester or quarter, winter quarter, or the spring semester or quarter.

"Undergraduate student" means a student in a program leading to an associate's or baccalaureate degree or a student enrolled in an undergraduate teacher certification program.

8VAC40-71-20. Institutional participation in the program: application procedures.

In order to participate in the program, eligible institutions not previously approved by the council to participate must file formal application with the council no later than January 31 of the calendar year preceding the calendar year in which fall term grants would first be available to students.

Applications shall be addressed to the council and shall include:

1. Estimates of the number of students who would be eligible to receive grants in the first and second years of participation;

2. A copy of the fiscal operations report and application to participate in federal student financial aid programs (FISAP) if participating in federal Title IV programs; and

3. Certifications from the institution's chief executive officer that the institution:

a. Meets each aspect of the definition of an eligible institution as defined in this chapter;

b. Offers academic programs that meet the definition of an eligible program and provides a list of such programs, including the officially recognized CIP codes for each program;

c. Will furnish whatever data the council may request in order to verify its institutional eligibility claims;

d. Will promptly notify the council within 30 days following any change in governance or mission that may affect the institution's status as an eligible institution;

e. By its governing body, has authorized its adherence to the requirements of this chapter, as the same are now constituted or hereafter amended, until such time as the institution may withdraw from participation in the program; and

f. Will comply with the council's reports requirements and deadlines.

Applications must be approved and all documents must be on file before any funds are disbursed.

Council retains the prerogative to issue conditional approval to participate in the program if deemed necessary and provide a timeframe in which a follow-up review will be conducted before issuing final approval.

All subsequent new programs or site locations must be reported to the council by no later than August 1 of the calendar year preceding the calendar year in which fall term grants would first be available to students in the program or at the new site location.

8VAC40-71-30. Disbursement of funds.

A. Advancement of funds. A percentage of an institution's estimated allocation of funds for a term will be forwarded to the institution at the beginning of the term. The allocation will be based primarily on the projected award for the term and each institution's prior academic year's enrollment unless the institution makes a convincing case by presenting new enrollment factors.

After the census date for each term, the institution will certify that recipients are enrolled as full-time students and are meeting other eligibility requirements established for the program. After enrollment is verified, additional funds, if needed, may be disbursed to the institution. Funds for recipients reported as not enrolled full time or not meeting other eligibility requirements shall not be disbursed to students, and funds for these students, if already received by the institution in its capacity as the student's fiscal agent, shall be returned to the council no later than the end of the fiscal year unless otherwise requested, in which case the deadline is within 30 days of the request.

B. Notification to students. The private institutions that participate in this program shall, during the spring semester previous to the commencement of a new academic year or as soon as a student is admitted for that academic year, whichever is later, notify their enrolled and newly admitted Virginia students about the availability of tuition assistance awards under the program. The information provided to students and their parents must include information about the eligibility requirements, the application procedures, and the fact that the amount of the award is an estimate and is not guaranteed. The number of students applying for participation and the funds appropriated for the program determine the amount of the award. Conditions for reduction of award amount and award eligibility are described in these regulations. The institutions shall certify to the council that such notification has been completed and shall indicate the method by which it was carried out.

Further, the institutions shall make students aware that the award is state funded. Evidence of such notification may include award letters or other formal procedures used by the institution for student notification of financial aid awards.

C. Restriction on use of funds. An institution shall establish and maintain financial records that accurately reflect all program transactions as they occur. The institution shall identify each program transaction and separate those transactions from all other institutional financial activity. Program funds shall be deposited in a noninterest-bearing account established and maintained exclusively for that purpose. Funds shall be disbursed only to student accounts receivable or returned to the council. The institution shall not hold program funds in the account for more than 20 working days before transferring funds to student accounts.

Funds received by the institutions under the program shall be used only to pay awards to students. The funds are held in trust on behalf of the Commonwealth of Virginia by the institutions for the intended student beneficiaries and shall not be used for any other purpose.

8VAC40-71-40. Student eligibility.

A. Receipt of application.

1. Applications submitted in person, by facsimile, or by other electronic means, or postmarked by carrier mail by the applicable deadline (July 31, September 14, and December 1) of the academic year may be deemed as meeting the deadline.

2. If the deadline occurs on a weekend or nonbusiness day as recognized by the institution or carrier, the application will be deemed as meeting the respective deadline if the application is received by the institution by the first business day following the deadline or postmarked by carrier mail by the carrier's first business day following the deadline.

3. Students who submit an application to one institution but enroll into another may still be considered to have met the respective deadline if the initial institution can verify receipt of the application by the deadline.

B. Priority for award. Because funds may not be sufficient to award all eligible students, students are prioritized based on prior eligibility (returning students) and date of application (new students). Below are descriptions of the students in priority order for receiving an award. Priority students will receive a full award before students in a subsequent priority order.

1. Category 1 and 2 students receive priority for an award.

a. Category 1 students: returning students who received an award in the previous fiscal year, including:

(1) Students returning to their original institution;

(2) Students transferring from another participating eligible institution; and

(3) Students moving from one degree level to another within an institution or from another participating eligible institution.

b. Category 2 students: students submitting a completed program application by July 31 of the fiscal year who were:

(1) New and readmitted students who were not enrolled in the previous fiscal year; or

(2) Returning students who met the domicile requirements in the previous fiscal year but did not receive an award due to insufficient funding (Category 3 and 4 students) or because they were not enrolled full time or otherwise did not meet other award criteria.

2. Category 3 students will be considered for an award if funds are available after Category 1 and 2 students are fully funded. Category 3 students are those who submit a

completed application after July 31 but no later than September 14, including:

a. New and readmitted students who were not enrolled in the previous fiscal year; or

b. Students enrolled but who did not apply for an award in the previous fiscal year.

3. Category 4 students will be considered for an award if funds are available after Category 1, 2, and 3 students are fully funded.

a. Category 4 students are those who submit a completed program application after September 14 but no later than December 1 of the fiscal year and include new and readmitted students who were not enrolled in the previous fiscal year.

b. Category 4 students receive spring term only awards.

4. Exceptions are made for students who break enrollment for military purposes. Students reentering their degree program within one year of completion of military responsibilities shall be granted priority, along with Category 1 students. This exception is for priority purposes only as the student still must meet all eligibility criteria.

C. Eligibility criteria. In order to be eligible to receive an award, the student must:

1. Be a domiciliary resident of Virginia, as defined by § 23-7.4 of the Code of Virginia, for at least one year prior to the date of entitlement (first day of classes for the program in which the student is enrolled) or eligible under § 23-7.4 E of the Code of Virginia.

2. Enroll in the academic year for which the award is to be received as a full-time student in an eligible program at a participating eligible institution.

a. A student's enrollment status shall be determined at the census date. If a student falls below full time by dropping or withdrawing from individual courses or withdraws from the institution after the census date, he shall receive a prorated award based on the tuition refund policy in effect at the institution.

b. A graduating student enrolled less than full time for a term in his final academic year may be eligible to receive an award if:

(1) The student was enrolled full time and accepted for or received an award in the immediate preceding academic year;

(2) The course credits available in the current term needed to complete degree requirements total less than a full-time course load; and

(3) The maximum number of years of eligibility has not been exceeded.

c. Exceptions to the full-time requirement due to a documented disability or other medical reasons, as applicable under the federal American's with Disabilities Act, will be considered on a case-by-case basis.

3. Have complied with federal selective service registration requirements unless the following apply:

a. The requirement to register has terminated or become inapplicable to the person; and

b. The person shows by preponderance of the evidence that failure to register was not a knowing and willful failure to register.

4. Complete and submit an application for an award by the published deadline.

5. Not participate in the Virginia Women’s Institute for Leadership at Mary Baldwin College.

D. Limitations on awards. For administrative purposes, each academic year shall be comprised of six units of program eligibility; accordingly, a semester is equivalent to three units and a quarter is equivalent to two units.

1. If a student receives a partial payment for a semester or quarter, the student's total eligibility shall be reduced by one semester (three units) or quarter (two units).

2. Undergraduate students:

a. Students pursuing an associate's degree shall be limited to a maximum of two academic years (12 units), or its equivalent, of support.

b. Students pursuing degrees at the undergraduate level shall be limited to a combined life-time maximum of four academic years (24 units), or its equivalent, of support, inclusive of enrollment in any combination of associate's or baccalaureate degrees.

c. Students enrolled in teacher certification programs at the undergraduate level may receive awards if the student is enrolled full time and has not exhausted eligibility.

3. Post-undergraduate students:

a. Students pursuing degrees at the graduate level shall be limited to a combined life-time maximum of three academic years (18 units), or its equivalent, of support.

b. Students pursuing degrees at the first-professional level shall be limited to a life-time maximum of three academic years (18 units), or its equivalent, of support, except for students pursuing medical or pharmacy degrees who are limited to four academic years (24 units), or its equivalent, of support.

c. In no case should any combination of post-undergraduate programs exceed four years of support.

4. A student enrolled at multiple institutions may receive an award if:

a. The home institution is an eligible institution;

b. A formal consortium agreement is in place; and

c. The student's combined enrollment is full time.

If the consortium agreement includes a Virginia public institution, the award will be prorated based on the courses for the term not attempted at the Virginia public institution as a percentage of minimum full-time enrollment.

5. A student may receive an award under a study abroad program if:

a. The student is enrolled full time;

b. The student remains on record as an enrolled student in an otherwise eligible program at a participating eligible institution for the term in which the award is received;

c. The program funds are disbursed to the participating eligible institution; and

d. The overseas program is a formal agreement arranged by the participating eligible institution.

E. Appeals process.

1. The participating institution makes the student's initial eligibility determination. If the institution determines that the student does not meet the domicile requirements, the institution must notify the student in writing of the outcome and the availability of the appeals process.

2. Council shall make final decisions on domicile eligibility disputes between students and the enrolling institutions. The appeal process for resolving eligibility disputes shall consist of a review of the institution's initial determination by a council staff member. Further student appeals are subject to a final review by a committee comprised of three council staff members. No person who serves at one level of the appeals process shall be eligible to serve at any other level of review. Timing for completion of the review is heavily dependent upon the response time to staff information requests for both the student and the institution, but typically council staff will respond within two weeks.

3. Student appeals must be filed in writing with the council within 30 days of the institution's written notification. If the outcome of the appeal upholds the institution's initial determination, the student may file a final appeal within 30 days of the council's written notification.

4. The appeals process is contained in this subsection and available to the institutions and students online or in print upon request.

8VAC40-71-50. Award amount.

A. Maximum annual award.

1. Section 23-38.14 of the Code of Virginia specifies that no annual award shall exceed the annual average appropriation per full-time equivalent student for the previous year from the general fund for operating costs at two-year and four-year public institutions of collegiate education in Virginia.

2. Council determines the amount of the annual award based on the number of eligible students and available funds. In no event shall the actual annual award amount exceed the maximum limit set forth in the annual appropriation act or in § 23-38.14 of the Code of Virginia.

B. An award received by a student under the program shall not be reduced by the institution unless:

1. Council authorizes a uniform reduction of the award for all students because it is determined that the number of priority students multiplied by the projected annual award amount exceeds available funds.

2. The award, when combined with all other financial assistance from any source, including, but not limited to, a scholarship, grant, tuition waiver, veteran benefits, or employer reimbursement, exceeds the estimated cost of attendance at the institution the student attends.

3. The student is enrolled less than the minimum credit hours as defined under "full-time student" but falls under one of the following exceptions:

a. The individual student falls under the enrollment provisions listed under 8VAC40-71-40 C 2; or

b. The student is a doctoral student taking less than 9 credit hours but declared full-time via institutional policy.

4. In such cases as described in this subsection, the student would receive an award prorated on a percentage basis based on the student's actual tuition charges as compared to the tuition typically charged by the institution to a full-time student.

C. When a reduced award is appropriate, all awards should be rounded to the nearest whole dollar.

D. For purposes of calculating federal Chapter 33 (Post-9/11 GI Bill) veteran's benefits, this award is not considered to be solely for the purpose of defraying tuition and fees.

8VAC40-71-60. Administration.

A. The council. The council retains the right to periodically review institutional administrative practices to determine compliance with this chapter. If the council determines that an institution has failed to rectify substantial compliance errors after an opportunity to do so is provided by the council,

or otherwise no longer meets the definition of an eligible institution, the council may, after a written notice of pending action to the institution, suspend or terminate its future participation in the program. In all instances, the council will require the institution to recover and refund to the council any state funds that were expended improperly. An institution that is suspended or terminated from the program may ask for reconsideration by submitting a written appeal within 30 days of the council's decision.

The council shall provide assistance, interpretation of policy and regulations, and guidance to the institution in their handling of administrative matters. The assistance may be in the form of information about the program and preparation of the student application.

If an institution wishes to do so, it may prepare its own application, as long as it is approved by the council.

B. Participating institutions. Institutions shall:

1. Certify student eligibility in all respects;

2. Notify, in writing, students whose applications are rejected that they are not eligible for awards, the reason they are not eligible, and the deadline date for submitting appeals to the council;

3. Use the program Units Web Tool, if available, to verify units used by students prior to making new awards;

4. Secure and provide to the council such information regarding student applicants and award recipients as the council deems necessary for the proper administration of the program;

5. Act, with the student's authorization, as the student's agent to receive and hold program funds for the student's use as tuition assistance;

6. Furnish periodic reports and other pertinent information as may be required by the council. The reports shall include, but not be limited to, copies of institutional financial aid audit reports and audited financial statements;

7. Ensure that each application bears a timestamp indicating the date the application was received by the institution;

8. Retain all records regarding the application and award process for at least three years after the last award year for the student unless directed otherwise by the Library of Virginia's Virginia Records Retention and Disposition, Schedule GS-111; and

9. Withdraw from the program only upon a 60-day written notice to both its student body and the council. Withdrawal shall be effective at the conclusion of the academic year designated by the withdrawing participant.

The institution's chief executive officer shall designate one individual at the institution to act as the primary representative of the institution in all matters pertaining to the administration of the program. The chief executive officer shall, in addition, indicate whether the primary institutional representative may designate a single subordinate who may act as an alternate representative for routine administrative operational matters at the campus. At multi-campus institutions, an alternate representative may be designated for each branch campus if the chief executive officer authorizes the appointment of alternate representatives. If there is a change in the primary representative, the chief executive officer shall designate another individual and notify the council in writing within 30 days of the change. It is the responsibility of the primary representative to advise the council in a similar fashion of changes in alternate representatives, if any.

C. Responsibility of recipients. A recipient of an award under the program shall notify the institution in writing of any name or permanent address change.

VA.R. Doc. No. R12-2378; Filed September 14, 2011, 10:31 a.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Final Regulation

REGISTRAR'S NOTICE: The State Board of Health has claimed an exemption from 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 Health will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **12VAC5-31. Virginia Emergency Medical Services Regulations (amending 12VAC5-31-50, 12VAC5-31-60, 12VAC5-31-110, 12VAC5-31-140).**

Statutory Authority: §§ 32.1-12 and 32.1-111.4 of the Code of Virginia.

Effective Date: November 1, 2011.

Agency Contact: Michael Berg, Regulatory and Compliance Manager, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7615, or email michael.berg@vdh.virginia.gov.

Summary:

The current Virginia EMS Regulations describing the process for exemption requests for agencies and entities require a resolution from the local governing body as part of the request process. The amendment allows the

flexibility for the chief administrative officer of a jurisdiction to approve such a request. In addition, the current regulations require an individual to obtain a resolution from the local governing body as part of the variance/exemption process. The amendment allows for the affiliated provider to seek only the signatures of the operational medical director and the chief officer of the agency with which they are affiliated. For those unaffiliated providers, the amendment allows for a simple application process that allows for additional documentation as required by the Commissioner of Health. This regulatory action conforms the Virginia EMS Regulations to the provisions of the Code of Virginia, as amended by Chapter 90 of the 2011 Acts of Assembly.

12VAC5-31-50. Variances.

A. The Office of EMS is authorized to grant variances for any part or all of these regulations in accordance with the procedures set forth herein. A variance permits temporary specified exceptions to these regulations. An applicant, licensee, or permit or certificate holder may file a written request for a variance with the Office of EMS on specified forms. If the applicant, licensee, or permit or certificate holder is an EMS agency, the following additional requirements apply:

1. The written variance request ~~must~~ shall be submitted for review and recommendations to the governing body or chief administrative officer of the ~~locality~~ jurisdiction in which the principal office of the EMS agency is located prior to submission to the Office of EMS.

2. An EMS agency operating in multiple ~~localities~~ jurisdictions will be required to notify all other ~~localities~~ jurisdictions in writing of conditions of approved variance requests.

3. Issuance of a variance does not obligate other ~~localities~~ jurisdictions to allow the conditions of such variance if they conflict with local ordinances or regulations.

4. Both the written request and the recommendation of the governing body or chief administrative officer shall be submitted together to the Office of EMS.

B. ~~Both the written request and the recommendation of the governing body must be submitted together to the Office of EMS.~~ If the applicant for a variance is an affiliated provider who is certified or a candidate for certification, the following requirements shall apply:

1. The written variance request shall be submitted for review and recommendations to the operational medical director and the head of the agency with which the provider is affiliated.

2. Both the written request and the recommendation of the operational medical director and the agency head shall be submitted to the Office of EMS.

C. Those providers who are not affiliated with an EMS agency shall submit their variance request to the commissioner for consideration. The commissioner may request additional case-specific endorsements or supporting documentation as part of the application.

12VAC5-31-60. Issuance of a variance.

A request for a variance may be approved and issued by the Office of EMS provided all of the following conditions are met:

1. The information contained in the request is complete and correct;

2. The agency, service, vehicle or person concerned is licensed, permitted or certified by the Office of EMS;

3. The Office of EMS determines the need for such a variance is genuine, and extenuating circumstances exist;

4. The Office of EMS determines that issuance of such a variance would be in the public interest and would not present any risk to, or threaten or endanger the public health, safety or welfare;

5. If the request is made by an EMS agency, the Office of EMS will consider the recommendation of the governing body or chief administrative officer provided all of the above conditions are met; ~~and~~

6. If the request is made by an affiliated provider who is certified or a candidate for certification, the Office of EMS will consider the recommendation of the operational medical director and the agency head for which the provider is affiliated; and

~~6.~~ 7. The person making the request will be notified in writing of the approval and issuance within 30 days of receipt of the request unless the request is awaiting approval or disapproval of a license or certificate. In such case, notice will be given within 30 days of the issuance of the license or certificate.

12VAC5-31-110. Exemptions.

A. The board is authorized to grant exemptions from any part or all of these regulations in accordance with the procedures set forth herein. An exemption permits specified or total exceptions to these regulations for an indefinite period.

B. Request. A person may file a written request for an exemption with the Office of EMS on specified forms. If the request is made by an EMS agency, the following additional requirements apply:

1. The written request for exemption must be submitted for review and recommendation to the governing body of the ~~locality~~ jurisdiction or chief administrative officer in which the principal office of the EMS agency is located before submission to the Office of EMS.

2. The written request must be submitted to the Office of EMS a minimum of 30 days before the scheduled review by the governing body or chief administrative officer. At the time of submission, the agency or service must provide the Office of EMS with the date, time and location of the scheduled review by the governing body or chief administrative officer.

3. Issuance of an exemption does not obligate other jurisdictions to allow the conditions of such exemption if they conflict with local ordinances or regulations.

4. Both the written request and the recommendation of the governing body or chief administrative officer shall be submitted together to the Office of EMS.

C. If the applicant for an exemption is an affiliated provider who is certified or a candidate for certification, the following requirements shall apply:

1. The written exemption request shall be submitted for review and recommendations to the operational medical director and the head of the agency with which the provider is affiliated.

2. Both the written request and the recommendation of the operational medical director and the agency head shall be submitted to the Office of EMS.

D. Those providers who are not affiliated with an EMS agency shall submit their exemption request to the commissioner for consideration. The commissioner may request additional case-specific endorsements or supporting documentation as part of the application.

12VAC5-31-140. Issuance of an exemption.

A. A request for an exemption may be approved and an exemption issued provided all of the following conditions are met:

1. The information contained in the request is complete and correct.

2. The need for such an exemption is determined to be genuine.

3. The issuance of an exemption would not present any risk to, threaten or endanger the public health, safety or welfare of citizens.

B. If the request is made by an EMS agency, the board may accept the recommendation of the governing body or chief administrative officer provided all of the conditions in subsection A of this section are met.

C. If the request is made by an affiliated provider who is certified or a candidate for certification, the board will consider the recommendation of the operational medical director and the agency head with which the provider is affiliated.

~~C.~~ D. The person making the request will be notified in writing of the approval or denial of a request.

VA.R. Doc. No. R12-2897; Filed August 31, 2011, 4:38 p.m.

Fast-Track Regulation

Title of Regulation: **12VAC5-67. Advance Health Care Directive Registry (adding 12VAC5-67-10, 12VAC5-67-20, 12VAC5-67-30).**

Statutory Authority: § 54.1-2995 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: October 26, 2011.

Effective Date: November 15, 2011.

Agency Contact: Kimberly S. Barnes, Policy Analyst, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7661, or email kim.barnes@vdh.virginia.gov.

Basis: Section 54.1-2995 of the Code of Virginia authorizes the Board of Health to adopt regulations to carry out the responsibility of the Department of Health to make available a secure online central registry for advance health care directives.

Purpose: The regulation will implement a central online registry accepting the submission by citizens of advance directives. An advance directive is a legally enforceable document that divulges and explains an individual's intentions regarding the continuation of medical care in the event of the individual's inability to make decisions as the need arises. The goal of the regulation is to effectively administer the registry to allow restricted access to such documents so that citizens' wishes regarding their intentions can be made available to hospitals and other providers of health care services, relatives, and others as needed and authorized. The regulation is essential to protect the welfare of citizens because it will allow a central and secure means for providers of health care services to quickly and accurately identify and understand a patient's wishes regarding the provision and continuation of health care services.

Rationale for Using Fast-Track Process: This regulation is expected to be noncontroversial. No opposition was voiced during the adoption of the enabling legislation during the 2008 Session of the General Assembly.

Substance: This regulation establishes the criteria for submission of an advance health care directive to the registry including the specific documents that may be submitted. This regulation also specifies the individuals authorized to submit such information.

Issues: This regulation allows a Virginia citizen to file an advance health care directive to a registry accessible to

selected family members or friends and health care treatment professionals.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapters 301 and 696 of the 2008 Acts of Assembly, the Board of Health (Board) proposes to establish regulations to govern the Advance Health Care Directive Registry.

Result of Analysis. The benefits likely exceed the costs for all proposed changes.

Estimated Economic Impact. Section 54.1-2995 D of the Code of Virginia directs the Board to promulgate regulations to (i) determine who may access the registry, (ii) ensure that registry users are annually reminded of which documents they have registered, and (iii) address fees for filing a document with the registry. For (i), the proposed regulations state that the person registering documents may specify a legal representative or other persons to have access to such documents. It shall be the responsibility of the person registering to provide all such persons with the information necessary to access the registry. In accordance with patient authorization, health care professionals may have access to the registry.

For (ii), the proposed regulations state that the department shall ensure that the contracted vendor, public-private partnership, or any other entity through which the department has made the registry available to citizens of the Commonwealth annually contacts persons who have registered documents to remind them of which documents they have registered.

For (iii), the proposed regulations state that the person submitting documents to the registry shall be responsible for payment of any fee required by the contracted vendor, public-private partnership, or any other entity through which the department has made the registry available to citizens of the Commonwealth. Fees associated with the registry shall not exceed the direct costs associated with the development and maintenance of the registry and with the education of the public about the availability of the registry. According to the Department of Health, Microsoft and Univel have agreed to maintain the registry for no charge.

The optional use of the registry is established by statute. The proposed regulations help enable the use of the optional registry with no burdensome requirements. Thus, the benefits of the proposed regulations exceed the costs.

Businesses and Entities Affected. Healthcare providers and all Virginians who may wish to keep records in the Advance Health Care Directive Registry are potentially affected.

Localities Particularly Affected. The proposed regulations do not disproportionately affect particular localities.

Projected Impact on Employment. The proposed regulations are unlikely to significantly affect employment.

Effects on the Use and Value of Private Property. The proposed regulations help enable the optional beneficial use of private records.

Small Businesses: Costs and Other Effects. The proposed regulations are unlikely to significantly affect small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The proposed regulations are unlikely to significantly affect small businesses.

Real Estate Development Costs. The proposed regulations are unlikely to significantly affect real estate development costs.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

Agency's Response to Economic Impact Analysis: The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget.

Summary:

Chapters 301 and 696 of the 2008 Acts of Assembly require the board to establish a secure online central registry for advance health care directives. The regulation describes the documents that may be submitted to the Advance Health Care Directive Registry, allows fees to be charged by a vendor with whom the Department of Health contracts to implement the registry, and specifies who is allowed to access documents in the registry.

CHAPTER 67
ADVANCE HEALTH CARE DIRECTIVE REGISTRY

12VAC5-67-10. General provisions.

A. In accordance with Article 9 (§ 54.1-2994 et seq.) of Chapter 29 of Title 54.1 of the Code of Virginia and this chapter, the Department of Health shall make available to the public an Advance Health Care Directive Registry by (i) contracting with a vendor, (ii) publicizing the availability of an existing registry maintained by another entity, or (iii) entering into a public-private partnership.

B. The department shall ensure that the contracted vendor, public-private partnership, or any other entity through which the department has made the registry available to citizens of the Commonwealth annually contacts persons who have registered documents to remind them of which documents they have registered.

12VAC5-67-20. Criteria for submission of an advance directive to the registry.

A. Documents that may be submitted to the registry include:

1. A health care power of attorney.

2. An advance directive created pursuant to Article 8 (§ 54.1-2981 et seq.) of Chapter 29 of Title 54.1 of the Code of Virginia or a subsequent act of the General Assembly.

3. A declaration of an anatomical gift made pursuant to the Revised Uniform Anatomical Gift Act (§ 32.1-291.1 et seq. of the Code of Virginia).

B. The document shall be submitted for filing only by the person who executed the document.

C. The person submitting documents to the registry shall be responsible for payment of any fee required by the contracted vendor, public-private partnership, or any other entity through which the department has made the registry available to citizens of the Commonwealth. Fees associated with the registry shall not exceed the direct costs associated with the development and maintenance of the registry and with the education of the public about the availability of the registry.

12VAC5-67-30. Access to the registry.

The person registering documents may specify a legal representative or other persons to have access to such documents. It shall be the responsibility of the person registering to provide all such persons with the information necessary to access the registry. In accordance with patient authorization, health care professionals may have access to the registry.

VA.R. Doc. No. R12-2750; Filed September 1, 2011, 12:50 p.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Health has claimed an exemption from 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 Health will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **12VAC5-410. Regulations for the Licensure of Hospitals in Virginia (amending 12VAC5-410-440).**

Statutory Authority: §§ 32.1-12 and 32.1-127 of the Code of Virginia.

Effective Date: November 1, 2011.

Agency Contact: Carrie Eddy, Policy Analyst, Department of Health, 3600 West Broad Street, Suite 216, Richmond, VA 23230-4920, telephone (804) 367-2157, FAX (804) 367-2149, or email carrie.eddy@vdh.virginia.gov.

Summary:

Pursuant to Chapter 621 of the 2011 Acts of Assembly, the amendment requires that, beginning July 1, 2012, hospitals providing maternity services offer to obtain a blood sample from an infant born at the hospital and provide the sample to the infant's mother.

12VAC5-410-440. Obstetric and newborn services general requirements.

A. Hospitals with licensed obstetric and newborn services in operation prior to August 10, 1995, or revisions to thereof shall comply with all of the requirements of this section with the exception of specified sections of 12VAC5-410-442. Hospitals that establish and organize obstetric and newborn services after August 10, 1995, shall comply with all requirements of this section and 12VAC5-410-441 through 12VAC5-410-447 before licensure approval is granted.

B. A hospital with organized obstetric and newborn services shall comply with the following general requirements:

1. The governing body of the hospital or the chief executive officer shall appoint an administrative manager for the obstetric and newborn services. The administrative manager may serve as an administrator of another hospital service but must be available to the obstetric and newborn services. The chief executive officer shall designate, in writing, an individual to act in the administrative manager's behalf during a temporary absence of the administrative manager.

2. The hospital is responsible for the development, periodic review and revision of a service management plan. The

plan must include provisions to assure that the hospital complies with all state and federal regulations and guidelines applicable to obstetric and newborn care as well as the policies and procedures for obstetric and newborn care adopted by the hospital's governing body and medical staff. The plan is to be developed and maintained as follows:

a. The plan shall be developed in cooperation with the medical directors and nursing staffs assigned to each of the services.

b. The plan shall include the protocol, required by § 32.1-127 of the Code of Virginia, for the admission or transfer of any pregnant woman who presents in labor.

c. The plan shall be the responsibility of the administrative manager who is to assure that the plan is developed, that it complies with state and federal requirements and the hospital's policies and procedures, and that it is periodically reviewed and revised.

d. A copy of the plan shall be readily available at each nursing station within the obstetric and newborn services for staff reference.

e. A copy of the plan shall be made available, upon request, to the licensing inspector for review.

3. The hospital shall provide the following services in support of the obstetric and newborn services units:

a. Clinical laboratory services and blood bank services shall be available in the hospital on a 24-hour basis. Laboratory and blood bank personnel shall be available on-site or on-call on a 24-hour basis. The blood bank shall have group O Rh negative blood available at all times and be able to provide correctly matched blood in 45 minutes from request. The hospital's laboratory and blood bank personnel must be capable of performing the following tests with less than 1.0 ml of blood within one hour of request or less if specified:

(1) Blood group and Rh type determination/cross matching

(2) Arterial blood gases within 20 minutes

(3) Blood glucose within 20 minutes

(4) Complete blood count

(5) Total protein

(6) Total bilirubin

(7) Direct Coombs test

(8) Electrolytes

(9) Blood urea nitrogen

(10) Clotting profile (may require more than one cc of blood).

b. Portable radiological services for basic radiologic studies in each labor room, delivery room, and nursery shall be available on call on a 24-hour basis.

c. In addition to the requirements specified in 12VAC5-410-240 anesthesia service personnel shall be available on-site or on-call to begin anesthesia within 30 minutes of notification.

C. Beginning July 1, 2012, hospitals providing maternity care shall offer to obtain a sample of blood from an infant born at the hospital and provide that sample to the mother of the infant.

VA.R. Doc. No. R12-2817; Filed September 2, 2011, 4:09 p.m.

Final Regulation

REGISTRAR'S NOTICE: The State Board of Health has claimed an exemption from 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 Health will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **12VAC5-410. Regulations for the Licensure of Hospitals in Virginia (amending 12VAC5-410-200, 12VAC5-410-1170).**

Statutory Authority: §§ 32.1-12 and 32.1-127 of the Code of Virginia.

Effective Date: November 1, 2011.

Agency Contact: Carrie Eddy, Senior Policy Analyst, Department of Health, 9960 Mayland Drive, Henrico, VA 23233, telephone (804) 367-2102, or email carrie.eddy@vdh.virginia.gov.

Summary:

Pursuant to Chapter 670 of the 2011 Acts of Assembly, the amendments require hospitals to have policies related to infection prevention, disaster preparedness, and facility security.

12VAC5-410-200. Organization.

A. The internal hospital organization shall be structured to include appropriate departments and services consonant with its statement of purpose.

B. Each hospital shall maintain clearly written definitions of its organization, authority, responsibility, and relationships.

C. Each hospital department and service shall maintain:

1. Clearly written definitions of its organization, authority, responsibility, and relationships; and

2. Written policies and procedures including ~~patient care where applicable.~~:

a. Patient care where applicable;

b. Infection prevention;

c. Disaster preparedness; and

d. Facility security.

12VAC5-410-1170. Policy and procedures manual.

A. Each outpatient surgical hospital shall develop a policy and procedures manual that shall include provisions covering the following items:

1. The types of emergency and elective procedures that may be performed in the facility.

2. Types of anesthesia that may be used.

3. Admissions and discharges, including criteria for evaluating the patient before admission and before discharge.

4. Written informed consent of patient prior to the initiation of any procedures.

5. Procedures for housekeeping and infection control and prevention.

6. Disaster preparedness.

7. Facility security.

B. A copy of approved policies and procedures and revisions thereto shall be made available to the OLC upon request.

C. Each outpatient surgical hospital shall establish a protocol relating to the rights and responsibilities of patients based on Joint Commission on Accreditation of Healthcare Organizations' Standards for Ambulatory Care (2000 Hospital Accreditation Standards, January 2000). The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities. Patients shall be given a copy of their rights and responsibilities upon admission.

D. Each outpatient surgical hospital shall obtain a criminal history record check pursuant to § 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy whose job duties provide access to controlled substances within the outpatient surgical hospital pharmacy.

VA.R. Doc. No. R12-2818; Filed September 2, 2011, 4:11 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Proposed Regulation

Title of Regulation: **12VAC30-120. Waivered Services (adding 12VAC30-120-1000, 12VAC30-120-1005, 12VAC30-120-1010, 12VAC30-120-1020, 12VAC30-120-1040, 12VAC30-120-1060, 12VAC30-120-1070, 12VAC30-120-1080, 12VAC30-120-1088, 12VAC30-120-1090; repealing 12VAC30-120-211 through 12VAC30-120-249).**

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: December 9, 2011.

Agency Contact: Sam Pinero, Long Term Care Division, Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA 23219, telephone (804) 786-2149, FAX (804) 786-1680, or email sam.pinero @dmas.virginia.gov.

Basis: 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.

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

This program is a waiver of federal comparability of services requirement because these covered waiver services are only provided to persons who qualify for this waiver program by being at risk of institutionalization. Most of DMAS home and community-based care waivers are designed, due to the diagnoses of the various target populations, as medical care

models. This mental retardation/intellectual disability waiver is more uniquely a social service than a medical model, at the urging of Department of Behavioral Health and Developmental Services and the advocacy community.

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

The MR/ID Waiver program provides supportive services in the homes and communities of persons with diagnoses of MR/ID or children younger than the age of six years who are at risk of developmental delay. This program permits these individuals to safely remain in their homes and communities rather than being institutionalized in an intermediate care facility for the mentally retarded (ICF/MR). The MR/ID Waiver program currently supports 8,052 slots (one slot per waiver enrollee).

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

Substance: The regulations affected by this action are the waiver programs, specifically Mental Retardation/Intellectual Disability (MR/ID) Waiver. The regulations at 12VAC30-120-211 through 12VAC30-120-249 are being repealed and the regulations at 12VAC 30-50-1000 through 12VAC30-50-1090 are being newly promulgated.

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

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

2. As part of the PCP process, DBHDS will identify one standardized assessment tool and schedule (every three years) to ensure consistency across Virginia in identifying individuals' needs for waiver supports and services. DBHDS will publish guidance documents for the MR/ID waiver that provide for this standardized assessment tool.

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

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

5. Virginia's MR waiver regulations have historically required that an individual choosing the consumer-directed model for the delivery of personal care assistance, respite care, and companion care services also must receive the services of a services facilitator. In CMS' most recent review of Virginia's MR/ID Waiver application for renewal, CMS instructed the Commonwealth that, because services facilitation is a waiver service, waiver individuals have the right to choose whether to receive services facilitation.

Therefore, Virginia removed the requirement from the waiver.

6. To ensure that the essential tasks related to the delivery of consumer-directed services continue to be performed, these regulations propose that the individual or the family/caregiver, as appropriate, may perform those tasks (e.g., development of a plan of supports, submission of the plan for prior authorization, record documentation, etc.) when services facilitation is not chosen by the individual or his family/caregiver. Also, as "services facilitation" is included in the waiver renewal as an optional service, rather than as an administrative activity, a definition has been added.

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

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

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

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

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The proposed regulations 1) require the use of statewide Supports Intensity Scale form, an assessment instrument, to comprehensively assess individuals' needs for supports and services received through the waiver every three years, 2) require case managers to conduct an annual risk assessment of individuals enrolled in waiver programs, 3) require persons whose services do not start within 30 days to be referred back to the local departments of social services for redetermination of eligibility, 4) make the utilization of a service facilitator by the recipient optional under the consumer directed model, 5) allow involuntary disenrollment from consumer directed model if consumer directed services are not working well for a recipient, 6) modify the process currently used to fill waiver slots to ensure the uniformity of the statewide process, 7) include provisions for electronic information exchange between the local departments of social services, the Department of Medical Assistance Services, and enrolled service providers for determination of the patient pay requirement for waiver services, 8) re-organize the existing requirements, incorporate new terminology, and update name changes and definitions, 9) pursuant to Item 297 YYY, Chapter 297 of the 2010 Acts of Assembly, reduce the annual limit an individual can receive from $5,000 to $3,000 for environmental modifications and assistive technology, and 10) revise the prior authorization of respite services from once a year up to 720 hours to once every six month up to 360 hours. Some of these proposed changes have been effective since October 2009 under emergency regulations.

Result of Analysis. The benefits likely exceed the costs for one or more proposed changes. There is insufficient data to accurately compare the magnitude of the benefits versus the costs for other changes.

Estimated Economic Impact. The Mental Retardation/Intellectual Disability (MR/ID) Waiver program is established under section 1915(c) of the federal Social Security Act, which encourages the states to provide home and community based services as alternatives to institutionalized care. The MR/ID Waiver program provides supportive services in the homes and communities of persons with diagnoses of MR/ID or children younger than the age of six years who are at risk of developmental delay. The main purpose of waiver programs is to prevent or delay placement of persons in institutions by providing care for individuals in their homes and communities consequently avoiding high long term care costs. States wishing to implement such waiver programs are required to demonstrate that the costs would be lower under a waiver than the related institutional placement. The MR/ID Waiver program currently supports 8,052 slots.

Department of Medical Assistance Services (DMAS) delegates to the Department of Behavioral Health and Developmental Services (DBHDS) some administrative tasks for this waiver. DBHDS has worked closely with DMAS on the referenced waiver submission as well as these proposed regulations.

Most of the proposed changes are required in order to meet the Centers for Medicare and Medicaid Services (CMS) requirements for the renewal of the MR/ID Waiver. CMS approved the request for the renewal effective July 1, 2009. The current MR/ID waiver will expire June 30, 2014. Some

of the proposed regulations have been effective since October 2009 under emergency regulations.

According to DMAS, CMS now requires that states use person centered planning (PCP) in their waiver programs to ensure that individuals enrolled in the state's home and community based waivers fully participate in the planning for their services and supports. Person centered planning goes beyond the traditional individualized planning processes used in the waiver. The person centered approach relies much less on the service system and focuses on the individual receiving waiver services and supports. To accomplish PCP across Virginia, these regulations incorporate the essential definitions and activities needed to implement PCP.

One of the proposed changes to enhance person centered planning is the use of the Supports Intensity Scale (SIS), an assessment instrument to comprehensively assess individuals needs for supports and services received through the MR/ID waiver every three years. The form supports the person centered planning process required for waiver approval. The initial supply of this form has been purchased by DBHDS using grant funds. After July 1, 2012, DBHDS will request federal financial participation for the administrative costs associated with the use of this form in the MR/ID waiver. DBHDS estimates that 3,334 to 5,000 forms needed per year at a maximum cost of $100,308 total funds ($50,150 federal share) for fiscal year 2012 and beyond. These estimates may vary based on the number of waiver slots funded by the General Assembly. The main benefit of this form is to ensure consistency across Virginia in identifying individuals' needs for waiver supports and services.

To enhance person centered planning, the proposed regulations also require case managers to conduct an annual risk assessment of individuals enrolled in waiver programs. While this requirement adds an additional task to case managers duties, no additional compensation is provided. The annual risk assessment is expected to mitigate the health and safety risks to the recipients.

Another proposed change requires that persons whose services do not start within 30 days must be referred back to the local department of social services for redetermination of eligibility. While this change has the potential to increase the administrative costs in terms of redetermination of eligibility, the number of cases where services do not start within 30 days is expected to be very low. This is because the individuals are unlikely to risk their eligibility by failing to initiate their services within 30 days due to long waiting list for this waivers services. In addition, income limits for redetermination of eligibility is lower making it more difficult to qualify for the waiver services. On the other hand, this requirement will ensure that services available through this waiver are utilized by recipients on a timely manner.

Another change makes the utilization of a services facilitator by the recipient optional under the consumer directed model. Certain waiver services such as personal care assistance, respite care, and companion services are allowed to be provided in a consumer directed model in addition to the historically provided agency directed model. The agency directed model uses enrolled provider companies who hire nurses, nurse aides, and assistants to render services to recipients according to a provider developed schedule and staffing assignments. The consumer directed model permits the recipient to be the employer (hiring, training, and firing) of his own assistant and schedule the assistants services (work schedule) consistent with the recipients needs, as they are documented in the recipients approved plan of care.

Previously, regulations have required that an individual choosing the consumer directed model for the delivery of personal care assistance, respite care and companion care services also must receive the services of a services facilitator. In CMS most recent review of Virginia's MR/ID Waiver application for renewal, CMS instructed the Commonwealth that because services facilitation is a waiver service, waiver individuals have the right to choose whether or not to receive services facilitation. Therefore, the proposed changes removed the requirement from the waiver.

To ensure that the essential tasks related to the delivery of consumer directed services continue to be performed, these regulations propose that the individual or the family/caregiver, as appropriate, may perform those tasks (e.g., development of a plan of supports, submission of the plan for prior authorization, record documentation, etc.) themselves when services facilitation is not chosen by the individual or his family/caregiver. Also, "services facilitation" is included in the waiver renewal as an optional service rather than as an administrative activity.

DMAS expects the number of individuals who may opt out of services facilitation to be between 0.5% and 1% of the total waiver recipients, or between 40 and 80 people. Since October 2009 when the emergency regulations have become effective, only one person has opted out of services facilitation. If an individual opts out of services facilitation, a reduction in expenditures may be expected as no reimbursements for this service will be made.[1] However, there is not a readily available estimate for the potential fiscal impact of this change.

The proposed changes also allow involuntary disenrollment from consumer directed model if consumer directed services are not working well for a recipient. Currently, DMAS does not have the ability to move recipients into the agency directed model if the recipient fails to comply with the requirements of the consumer directed model or if there are health and safety risks to the recipient under the consumer directed model. For example, if the recipient is consistently unable to manage the assistant and has a pattern of discrepancies in time sheets of his or her assistant, DMAS

will have the authority to provide services to that individual under the agency directed model.

Currently, there are about 1,200 people in this waiver who are using the consumer directed model of service delivery. DMAS expects the number of persons being removed involuntarily to be very small, 0.5% to 1.0% of those persons who use this service model. Consequently, it is estimated that 6 to 12 persons may be affected by this change. Generally, the rates for agency directed services are higher than the rates paid in consumer directed services.[2] Thus, removing individuals from consumer directed model to agency directed model has the potential to increase expenditures. However, prevention of non-compliance with the requirements of consumer directed model may create fiscal savings and/or improve health and safety of recipients.

CMS further directed Virginia to modify the process currently used to fill MR/ID waiver slots to ensure the uniformity of the statewide process. CMS is now requiring that Virginia, through DBHDS, develop uniform, statewide guidelines to be applied by community services boards (CSBs) and behavioral health authorities (BHAs) to identify those urgent waiting list individuals who are most in need of services when waiver slots become available. These proposed regulations create the DBHDS' authority to accomplish this federal directive. This change is expected to provide consistency in eligibility determinations throughout the Commonwealth. On the other hand, some administrative costs associated with the development and the implementation of uniform criteria statewide may be expected.

The proposed regulations also include DMAS' conversion to an electronic information exchange between the local departments of social services, DMAS, and enrolled MR/ID service providers for determination of the patient pay requirement for waiver services. Electronic exchange of patient pay information is expected to reduce administrative costs associated with distribution of paper copies.

In addition, the proposed regulations re-organize the existing requirements, incorporate the use of current terminology (e.g., "replace mental retardation" with "mental retardation/intellectual disability"), change the name of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to the Department of Behavioral Health and Developmental Services (DBHDS), and add definitions for person centered terms such as "Person Centered Planning (PCP)," "Individual Support Plan," and "Plan for Supports."

Furthermore, pursuant to Item 297 YYY, Chapter 297 of the 2010 Acts of Assembly, the proposed regulations reduce the annual limit an individual can receive from $5,000 to $3,000 for environmental modifications and assistive technology. The main benefit of this change is the expected approximately $1.2 million savings per year in total funds starting with fiscal year 2010 and beyond. One half of these funds would represent savings in state funds. On the other hand, the main cost of this change is the expected reduction in the utilization of this service and its affects on the recipients.

Finally, one of the proposed changes revises the prior authorization of respite services from once a year up to 720 hours to once every six month up to 360 hours. Since the annual limit for the respite care hours stays the same, DMAS does not expect a significant reduction in the utilization and consequently in the expenditures for respite care. However, an increase in administrative costs of providers may be expected as they will be required to obtain additional prior authorizations for the same number of respite care hours. Due to the added costs and administrative requirements, there may be a small reduction in the prior authorization requests.

Businesses and Entities Affected. Currently, approximately 8,052 individuals are utilizing waiver services. The waiver services are provided by about 1,825 providers which include home health agencies, community services boards, and private providers of crisis stabilization, day support, in-home residential support, personal care, durable medical equipment, prevocational services, respite care, skilled nursing, supported employment, therapeutic consultation, and transition services.

Also, there are 122 local departments of social services making eligibility determinations. The waiver services are primarily administered by the Department of Behavioral Health and Developmental Services and paid through the Department of Medical Assistance Services.

Localities Particularly Affected. The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment. Some of the proposed changes are expected to increase the need for labor and add to the demand for labor. These changes include the required use of supports intensity scale, conducting a risk assessment every year, and the added prior authorization requirements.

Moreover, the providers are expected to see a decrease in demand for their services due to the reduced maximum expenditure limits for environmental modifications and assistive technology and making the use of service facilitator optional which may reduce providers demand for labor.

On the other hand, the printing of required supports intensity scale forms may add slightly to the demand for labor.

Effects on the Use and Value of Private Property. No direct effect on the use and value of private property is expected. However, added labor costs coupled with reduced revenues may have a negative impact on the asset value of affected providers.

Small Businesses: Costs and Other Effects. Approximately 1,621 of the affected 1,825 providers are estimated to be small businesses. The costs and other effects described above for all providers are the same for the providers that are small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact. There is no known alternative method that minimizes adverse impact on small businesses while accomplishing the same goals.

Real Estate Development Costs. No significant impact on real estate development costs is expected.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.H of the Administrative Process Act and Executive Order Number 107 (09). Section 2.2-4007.H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, § 2.2-4007.H requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

[1] The rates for facilitation services are as follows: Initial Comprehensive Visit $232.81 for Northern Virginia and $179.34 for the rest of the state; Routine Visit $72.41 for Northern Virginia and $55.70 for the rest of the state; Employee Management Training/Consumer Training $231.70 for Northern Virginia and $178.23 for the rest of the state; Management Training $28.96 for Northern Virginia and $22.28 for the rest of the state; and Reassessment Visit $116.97 for Northern Virginia and $89.12 for the rest of the state.

[2] The rates for Companion Care, Personal Care, and Respite Care under consumer directed model for Northern Virginia are $11.47 and the rates under agency directed model for Northern Virginia are $15.20; the rates under consumer directed model for the rest of the state are $8.86 and the rates under agency directed model for the rest of the state are $12.91.

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 Waiver Services: Mental Retardation/Intellectual Disabilities. The agency raises no issues with this analysis.

Summary:

The proposed amendments (i) require the use of a statewide Supports Intensity Scale form, an assessment instrument, to comprehensively assess individuals' needs for supports and services received through the waiver every three years; (ii) require case managers to conduct an annual risk assessment of individuals enrolled in waiver programs; (iii) require persons whose services do not start within 30 days to be referred back to the local departments of social services for redetermination of eligibility; (iv) make the utilization of a service facilitator by the recipient optional under the consumer-directed model; (v) allow involuntary disenrollment from consumer-directed model if consumer-directed services are not working well for a recipient; (vi) modify the process currently used to fill waiver slots to ensure the uniformity of the statewide process; (vii) include provisions for electronic information exchange between the local departments of social services, the Department of Medical Assistance Services, and enrolled service providers for determination of the patient pay requirement for waiver services; (viii) reorganize the existing requirements, incorporate new terminology, and update name changes and definitions; (ix) pursuant to Item 297 YYY, Chapter 297 of the 2010 Acts of Assembly, reduce the annual limit an individual can receive for environmental modifications and assistive technology from $5,000 to $3,000; and (x) revise the prior authorization of respite services from once a year up to 720 hours to once every six month up to 360 hours.

~~Part IV~~
~~Mental Retardation Waiver~~

~~Article 1~~
~~Definitions and General Requirements~~

12VAC30-120-211. ~~Definitions.~~ (Repealed.)

~~"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 service needs.~~

~~"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.~~

~~"Assistive technology" or "AT" means specialized medical equipment and supplies to include devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which 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, and durable and nondurable medical equipment not available under the Medicaid State Plan.~~

~~"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 1 (§ 37.2-100) 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.~~

~~"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.~~

~~"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 on behalf of the community services board or behavioral health authority possessing 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.~~

~~"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.~~

~~"Companion" means, for the purpose of these regulations, a person who provides companion services.~~

~~"Companion services" means nonmedical care, support, and socialization, provided to an adult (age 18 and over). The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the consumer service plan and is not purely diversional in nature.~~

~~"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-directed model" means services for which the individual and the individual's family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the staff.~~

~~"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and the individual's family/caregiver, as appropriate, by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.~~

~~"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive mental retardation waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The individual service plans are incorporated in the CSP by the case manager.~~

~~"Crisis stabilization" means direct intervention to persons with mental retardation 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.~~

~~"DMAS" means the Department of Medical Assistance Services.~~

~~"DMAS staff" means persons employed by 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.~~

~~"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.~~

~~"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/caregiver's, as appropriate, use of the providers' services.~~

~~"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the MR Waiver and DMHMRSAS has verified the availability of a MR Waiver slot for that individual, and DSS has determined the individual's Medicaid eligibility for home and community-based services.~~

~~"Entrepreneurial model" means a small business employing eight or fewer individuals who have disabilities on a shift and usually involves interactions with the public and with coworkers without 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) that are necessary to ensure the individual's 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 the individual.~~

~~"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.~~

~~"Fiscal agent" means an agency or organization within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal assistance, respite, and companion services.~~

~~"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, welfare, and safety standard" means 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 individual service plan and that services can safely be provided in the community.~~

~~"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(c) of the Social Security Act to be offered to persons with mental retardation and children younger than age six who are at developmental risk who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR.)~~

~~"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.~~

~~"Individual" means the person receiving the services or evaluations established in these regulations.~~

~~"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.~~

~~"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.~~

~~"ISAR" means the Individual Service Authorization Request and is the DMAS form used by providers to request prior authorization for MR waiver services.~~

~~"Mental retardation" 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.~~

~~"Pend" means delaying the consideration of an individual's request for services until all required information is received by DMHMRSAS.~~

~~"Personal assistance services" means assistance with activities of daily living, instrumental activities of daily living, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition.~~

~~"Personal assistant" means a person who provides personal assistance services.~~

~~"Personal emergency response system (PERS)" is an electronic device that enables certain individuals at high risk of institutionalization 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.~~

~~"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. 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.~~

~~"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 providing such care.~~

~~"Qualified mental retardation professional" or "QMRP" means a professional possessing: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.~~

~~"Residential support services" means support provided in the individual's home by a DMHMRSAS-licensed residential provider or a DSS-approved provider of adult foster care services. This service is one in which training, assistance, and supervision is routinely provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living and safety in the use of community resources, to adapt their behavior to community and home-like environments, to develop relationships, and 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.~~

~~"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and the individual's family/caregiver, as appropriate, by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for services with an option of a consumer-directed model. These services include companion, personal assistance, and respite services.~~

~~"Skilled nursing services" means services that are ordered by a physician and required to prevent institutionalization, that are not otherwise available under the State Plan for Medical Assistance and that are provided by a licensed registered professional nurse, or by a licensed practical nurse under the supervision of a licensed registered professional nurse, in each case who is licensed to practice in the Commonwealth.~~

~~"Slot" means an opening or vacancy of waiver services for an individual.~~

~~"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.~~

~~"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.~~

~~"Support plan" means the report of recommendations resulting from a therapeutic consultation.~~

~~"Therapeutic consultation" means activities to assist the individual and the individual's family/caregiver, as appropriate, staff of residential support, day support, and any other providers in implementing an individual service plan.~~

~~"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 own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

12VAC30-120-213. ~~General coverage and requirements for MR waiver services.~~ (Repealed.)

~~A. Waiver service populations. Home and community-based waiver services shall be available through a § 1915(c) of the Social Security Act waiver for the following individuals who have been determined to require the level of care provided in an ICF/MR.~~

~~1. Individuals with mental retardation; or~~

~~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 mental retardation to continue to receive home and community-based waiver services specifically under this program. Mental Retardation (MR) Waiver recipients who attain the age of six years of age, who are determined to not have a diagnosis of mental retardation, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for transfer to the IFDDS Waiver effective up to their seventh birthday. Psychological evaluations (or standardized developmental assessment for children under six years of age) confirming diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These recipients transferring from the MR Waiver will automatically be assigned a slot in the IFDDS Waiver, subject to the approval of the slot by CMS. The case manager will submit the current Level of Functioning Survey, CSP 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, the case manager will provide the family with a list of IFDDS Waiver case managers. The case manager will work with the selected IFDDS Waiver case manager to determine an appropriate transfer date and submit a DMAS-122 to the local DSS. The MR Waiver slot will be held by the CSB until the child has successfully transitioned to the IFDDS Waiver. Once the child has successfully transitioned, the CSB will reallocate the slot.~~

~~B. Covered services.~~

~~1. Covered services shall include: residential support services, day support, supported employment, personal assistance (both consumer-directed and agency-directed), respite services (both consumer-directed and agency-directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, prevocational services, personal emergency response systems (PERS), companion services (both consumer-directed and agency-directed), and transition services.~~

~~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 12VAC30-50-450. 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(c) waiver, DMAS waives § 1902(a)(10)(B) of the Social Security Act related to comparability.~~

~~C. Requests for increased services. All requests for increased waiver services by MR Waiver recipients will be reviewed under the health, welfare, and safety standard. This standard assures 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 ISP and that services can safely be provided in the community.~~

~~D. 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.~~

~~E. Urgent criteria. The CSB/BHA will determine, from among the individuals included in the urgent category, who should be served first, based on the needs of the individual at the time a slot becomes available and not on any predetermined numerical or chronological order.~~

~~1. The urgent category will be assigned when the individual is in need of services because he is determined to meet one of the criteria established in subdivision 2 of this subsection and services are needed within 30 days. Assignment to the urgent category may be requested by the individual, his legally responsible relative, or primary caregiver. The urgent category may be assigned only when the individual, the individual's spouse, or the parent of an individual who is a minor child would accept the requested service if it were offered. Only after all individuals in the Commonwealth who meet the urgent criteria have been served can individuals in the nonurgent category be served. Individuals in the nonurgent category are 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. In the event that a CSB/BHA has a vacant slot and does not have an individual who meets the urgent criteria, the slot can be held by the CSB/BHA for 90 days from the date it is identified as vacant, in case someone in an urgent situation is identified. If no one meeting the urgent criteria is identified within 90 days, the slot will be made available for allocation to another CSB/BHA in the Health Planning Region (HPR). If there is no urgent need at the time that the HPR is to make a regional reallocation of a waiver slot, the HPR shall notify DMHMRSAS. DMHMRSAS shall have the authority to reallocate said slot to another HPR or CSB/BHA where there is unmet urgent need. Said authority must be exercised, if at all, within 30 days from receiving such notice.~~

~~2. Satisfaction of one or more of the following criteria shall indicate that the individual should be placed on the urgent need of waiver services list:~~

~~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 individual 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 individual with mental retardation;~~

~~c. There is a clear risk of abuse, neglect, or exploitation;~~

~~d. A primary caregiver has a chronic or long-term physical or psychiatric condition or conditions which significantly limits the abilities of the primary caregiver or caregivers to care for the individual with mental retardation;~~

~~e. Individual is aging out of publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or~~

~~f. The individual with mental retardation lives with the primary caregiver and there is a risk to the health or safety of the individual, primary caregiver, or other individual living in the home due to either of the following conditions:~~

~~(1) The individual's behavior or behaviors present a risk to himself or others which 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.~~

~~F. Reevaluation of service need and utilization review. Case managers shall complete reviews and updates of the CSP and level of care as specified in 12VAC30-120-215 D. Providers shall meet the documentation requirements as specified in 12VAC30-120-217 B.~~

12VAC30-120-215. ~~Individual eligibility requirements.~~ (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 435.211, 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 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 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(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 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 under both this waiver and the mental retardation day support 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 allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)~~

~~(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 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 under both this waiver and the mental retardation day support 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 allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)~~

~~(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.~~

~~3. The following four criteria shall apply to all mental retardation waiver services:~~

~~a. Individuals qualifying for mental retardation waiver services must have a demonstrated need for the service resulting in significant functional limitations in major life activities. The need for the service must arise from either (i) an individual having a diagnosed condition of mental retardation or (ii) a child younger than six years of age being at developmental risk of significant functional limitations in major life activities;~~

~~b. The CSP and services that are delivered must be consistent with the Medicaid definition of each service;~~

~~c. Services must be recommended by the case manager based on a current functional assessment using a DMHMRSAS approved assessment instrument and a demonstrated need for each specific service; and~~

~~d. Individuals qualifying for mental retardation waiver services must meet the ICF/MR level of care criteria.~~

~~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 who are eligible for admission to an ICF/MR with a diagnosis of mental retardation, or who are under six years of age and at developmental risk. For the case manager to make a recommendation for waiver services, MR Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR, 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 the initiation of 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 enrollment;~~

~~c. The level of care required by applying the existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.) completed no more than six months prior to enrollment. The case manager determines whether the individual meets the ICF/MR 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 in the community; and~~

~~d. A psychological evaluation or standardized developmental assessment for children under six years of~~

~~age 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 the individual's family/caregiver, as appropriate, with the choice of MR waiver services or ICF/MR placement.~~

~~4. The case manager shall send the appropriate forms to DMHMRSAS to enroll the individual in the MR Waiver or, if no slot is available, to place the individual on the waiting list. DMHMRSAS shall only enroll the individual if a slot is available. If no slot is available, the individual's name will be placed on either the urgent or nonurgent statewide waiting list until such time as a slot becomes available. Once notification has been received from DMHMRSAS that the individual has been placed on either the urgent or nonurgent waiting list, the case manager must notify the individual in writing within 10 business days of his placement on either list, and offer appeal rights. The case manager will contact the individual and the individual's family/caregiver, as appropriate, at least annually to provide the choice between institutional placement and waiver services while the individual is on the waiting list.~~

~~C. Waiver approval process: authorizing and accessing services.~~

~~1. Once the case manager has determined an individual meets the functional criteria for mental retardation (MR) waiver services, has determined that a slot is available, and that the individual has chosen MR waiver services, the case manager shall submit 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 confirmation of enrollment from DMHMRSAS, the case manager shall inform the individual and the individual's family/caregiver, as appropriate, so that the CSP can be developed. The individual and the individual's family/caregiver, as appropriate, will meet with the case manager within 30 calendar days 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 shall provide the individual and the individual's family/caregiver, as appropriate, with choice of needed services available under the MR Waiver, alternative settings and providers. A CSP shall be developed for the individual based on the assessment of needs as reflected in the level of care and functional assessment instruments and the individual's and the individual's family/caregiver's, as appropriate, 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.~~

~~4. The individual or case manager shall contact chosen service providers so that services can be initiated within 60 days of receipt of enrollment confirmation from DMHMRSAS. The service providers in conjunction with the individual and the individual's family/caregiver, as appropriate, and case manager will develop ISPs for each service. A copy of these plans will be submitted to the case manager. The case manager will review and ensure the ISP meets the established service criteria for the identified needs prior to submitting to DMHMRSAS for prior authorization. The ISP from each waiver service provider shall be incorporated into the CSP. Only MR Waiver services authorized on the CSP by DMHMRSAS according to DMAS policies may be reimbursed by DMAS.~~

~~5. 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 working 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 prior authorization is required.~~

~~6. MR 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, Mental Retardation: Definition, Classification, and System of Supports, 10th Edition, 2002, or is a child under the age of six at developmental risk, and would in the absence of waiver services, require the level of care provided in an ICF/MR 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.~~

~~7. All consumer service plans are subject to approval by DMAS. DMAS is the single state agency authority~~

~~responsible for the supervision of the administration of the MR Waiver.~~

~~8. If services are not initiated by the provider within 60 days, 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 and the individual's family/caregiver, as appropriate. DMHMRSAS has the authority to approve the request in 30-day extensions, up to a maximum of four consecutive extensions, or 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 working days of the receipt of the request for extension.~~

~~D. Reevaluation of service need.~~

~~1. The consumer service plan (CSP).~~

~~a. The CSP shall be 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 is 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.~~

~~c. Any modification to the amount or type of services in the CSP must be preauthorized by DMHMRSAS or DMAS.~~

~~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 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 and the individual's family/caregiver, as appropriate, 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. A psychological evaluation or standardized developmental assessment for children under six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities.~~

~~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 onsite visits for all MR waiver individuals residing in DSS-licensed assisted living facilities or approved adult foster care placements.~~

~~5. The case manager must obtain an updated DMAS-122 form from DSS annually, designate a collector of patient pay when applicable and forward a copy of the updated DMAS-122 form to all service providers and the consumer-directed fiscal agent if applicable.~~

12VAC30-120-217. ~~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 five 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 agencies 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 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. Pursuant to 42 CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable state or federal law, hold confidential and use for authorized DMAS or DMHMRSAS 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 is necessary for the functioning of the DMAS in conjunction with the cited laws;~~

~~13. 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;~~

~~14. For all facilities covered by § 1616(e) of the Social Security Act in which home and community-based waiver services will be provided, be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS' licensure standards or through DSS-approved standards for adult foster care providers;~~

~~15. 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~~

~~16. Adhere to the provider participation agreement and the DMAS provider service 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 and the individual's family/caregiver, as appropriate, consultants, providers, DMHMRSAS, DMAS, DSS, DRS or other related parties; and~~

~~e. An ongoing log that documents all contacts made by the case manager related to the individual and the individual's family/caregiver, as appropriate.~~

~~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. Utilization 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:~~

~~a. All assessments and reassessments.~~

~~b. All ISP's developed for that individual and the written reviews.~~

~~c. Documentation of the date services were rendered and 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.~~

~~C. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides MR Waiver services for the individual.~~

12VAC30-120-219. ~~Participation standards for home and community-based waiver services participating providers.~~ (Repealed.)

~~A. Requests for 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. For services that have licensure and certification requirements, 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 providers in the community in which he desires services and he 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 assuring 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. 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.~~

~~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 specified in the termination notice.~~

~~F. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.~~

~~G. Section 32.1-325 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, DC, 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, when any of the following circumstances occur. Furthermore, it shall be the responsibility of DMHMRSAS to update DMAS, as requested, when any of the following events occur:~~

~~1. Home and community-based waiver services are implemented.~~

~~2. A recipient dies.~~

~~3. A recipient is discharged from all MR 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 and the individual's family/caregiver, as appropriate, 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 management provider. Providers of direct service are responsible for modifying their ISPs with the involvement of the individual and the individual's family/caregiver, as appropriate, and submitting ISPs to the case manager any time there is a change in the individual's condition or circumstances which 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 working days of receipt of the request for change.~~

~~The individual and the individual's family/caregiver, as appropriate, 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 12VAC30-110. 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 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 and the effective date the provider is discontinuing services. The effective date shall be at least 12 days from the date of the notification letter. The individual is not eligible for appeal rights in this situation and may pursue services from another provider.~~

~~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 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.~~

~~Article 2~~
~~Covered Services and Limitations and Related Provider Requirements~~

12VAC30-120-221. ~~Assistive technology.~~ (Repealed.)

~~A. Service description. AT is the specialized medical equipment and supplies including those devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which 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.~~

~~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 the individual's home, vehicle, 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. AT shall be covered in the least expensive, most cost-effective manner.~~

~~C. Service units and service limitations. Assistive technology is available to individuals who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. The combined total of assistive technology items and labor related to these items may not exceed $5,000 per CSP year. Costs for assistive technology cannot be carried over from year to year and must be preauthorized each CSP year. AT shall not be approved for purposes of convenience of the caregiver or restraint of the individual. An independent professional consultation must be obtained from staff knowledgeable of that item for each AT request prior to approval by DMHMRSAS. All AT must be preauthorized by DMHMRSAS each CSP year. Equipment/supplies/technology not available as durable medical equipment through the State Plan may be purchased and billed as assistive technology as long as the request for equipment/supplies/technology is documented and justified in the individual's ISP, recommended by the case manager, preauthorized by DMHMRSAS, and provided in the least expensive, most cost-effective manner.~~

~~D. 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, assistive technology shall be provided by a DMAS-enrolled Durable Medical Equipment provider or a DMAS-enrolled CSB/BHA with a MR Waiver provider agreement to provide assistive technology. The provider documentation requirements are as follows:~~

~~1. The appropriate ISAR form, to be completed by the case manager, may serve as the ISP, provided it adequately documents the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of evaluation or design, or both, labor, and supplies or materials, or both. The ISP/ISAR must~~

~~include documentation of the reason that a rehabilitation engineer is needed, if one is to be involved. A rehabilitation engineer may be involved if disability expertise is required that a general contractor will not have. The ISAR must be submitted to DMHMRSAS for authorization to occur;~~

~~2. 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 and supplies and that it is not available from a DME provider when purchased elsewhere;~~

~~3. Documentation of the recommendation for the item by a qualified professional;~~

~~4. Documentation of the date services are rendered and the amount of service 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 of satisfactory completion or receipt of the service or item; and~~

~~7. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.~~

12VAC30-120-223. ~~Companion services.~~ (Repealed.)

~~A. Service description. Companion services provide nonmedical care, socialization, or support to an adult (age 18 or older). Companions may assist or support the individual with such tasks as meal preparation, community access and activities, laundry and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks. This service is provided in accordance with a therapeutic goal in the CSP and is not purely diversional in nature. This service may be provided either through an agency-directed or a consumer-directed model.~~

~~B. Criteria.~~

~~1. In order to qualify for companion services, the individual shall have demonstrated a need for assistance with IADLs, light housekeeping, community access, reminders for medication self-administration or support to assure safety. The provision of companion services does not entail hands-on care.~~

~~2. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-225.~~

~~C. Service units and service limitations.~~

~~1. The unit of service for companion services is one hour and the amount that may be included in the ISP shall not exceed eight hours per 24-hour day. There is a limit of 8 hours per 24-hour day for companion services, either agency or consumer-directed or combined.~~

~~2. A companion shall not be permitted to provide the care associated with ventilators, continuous tube feedings, or suctioning of airways.~~

~~3. The hours authorized are based on individual need. No more than two unrelated individuals who are receiving waiver services and live in the same home are permitted to share the authorized work hours of the companion.~~

~~D. 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, companion service providers must meet the following qualifications:~~

~~1. Companion services providers.~~

~~a. Agency-directed model: must be licensed by DMHMRSAS as a residential service provider, supportive in-home residential service provider, day support service provider, or respite service provider or meet the DMAS criteria to be a personal care/respite care provider.~~

~~b. Consumer-directed model: a services facilitator meeting the requirements found in 12VAC30-120-225.~~

~~2. Companion qualifications. Companions must meet the following requirements:~~

~~a. Be at least 18 years of age;~~

~~b. Be able to read and write English and possess basic math skills;~~

~~c. Be capable of following an ISP with minimal supervision;~~

~~d. Submit to a criminal history record check within 15 days from the date of employment. 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;~~

~~f. Be capable of aiding in instrumental activities of daily living; and~~

~~g. Receive an annual tuberculosis (TB) screening.~~

~~3. Companion service providers 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 service. Companion services shall not be provided by adult~~

~~foster care providers or any other paid caregivers for an individual residing in that home.~~

~~4. Family members who are reimbursed to provide companion services must meet the companion qualifications.~~

~~5. For the agency-directed model, companions will be employees of providers that will have participation agreements with DMAS to provide companion services. Providers will be required to have a companion services supervisor to monitor companion services. The supervisor must have a bachelor's degree in a human services field and at least one year of experience working in the mental retardation field, or be an LPN or an RN with at least one year of experience working in the mental retardation field. An LPN or RN must have a current license or certification to practice nursing in the Commonwealth within his profession.~~

~~6. The supervisor or services facilitator must conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of services and to establish an individual service plan for the individual. The supervisor or services facilitator must provide follow-up home visits to monitor the provision of services quarterly under the agency-directed model and semi-annually (every six months) under the consumer-directed model or as often as needed.~~

~~7. Required documentation in the individual's record. The provider or services facilitator must maintain a record of each individual receiving companion services. At a minimum these records must contain:~~

~~a. An initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;~~

~~b. An ISP containing the following elements:~~

~~(1) The individual's strengths, desired outcomes, required or desired supports, or both;~~

~~(2) The services to be rendered and the schedule of services to accomplish the above outcomes;~~

~~c. Documentation that the ISP goals, objectives, and activities have been reviewed by the provider or services facilitator quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews 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 and the individual's family/caregiver, as appropriate.~~

~~d. All correspondence to the individual and the individual's family/caregiver, as appropriate case manager, DMAS, and DMHMRSAS;~~

~~e. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;~~

~~f. The companion services supervisor or services facilitator must document in the individual's record in a summary note following significant contacts with the companion and home visits with the individual that occur at least quarterly under the agency-directed model and at least semi-annually under the consumer-directed model:~~

~~(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;~~

~~(4) The presence or absence of the 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.~~

~~g. A copy of the most recently completed DMAS-122. The provider or services facilitator must clearly document efforts to obtain the completed DMAS-122 from the case manager.~~

~~h. Agency-directed provider companion records. In addition to the above requirements, the companion record for agency-directed providers must contain:~~

~~(1) The specific services delivered to the individual by the companion, dated the day of service delivery, and the individual's responses;~~

~~(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 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.~~

~~i. Consumer-directed model companion record. In addition to the above requirements outlined in subdivisions D 7 a through g of this section, the companion record for services facilitators must contain:~~

~~(1) The services facilitator's dated notes documenting any contacts with the individual and the individual's family/caregiver, as appropriate, and visits to the individual's home;~~

~~(2) Documentation of all training provided to the companion on behalf of the individual and the individual's family/caregiver, as appropriate;~~

~~(3) Documentation of all employee management training provided to the individual and the individual's family/caregiver, as appropriate, including the individual's and the individual's family/caregiver's, as appropriate, receipt of training on their responsibility for the accuracy of the companion's timesheets; and~~

~~(4) All documents signed by the individual and the individual's family/caregiver, as appropriate, that acknowledge the responsibilities as the employer.~~

12VAC30-120-225. ~~Consumer-directed model of service delivery.~~ (Repealed.)

~~A. Criteria.~~

~~1. The MR Waiver has three services, companion, personal assistance, and respite, that may be provided through a consumer-directed model. Effective July 1, 2011, respite services shall be limited to 480 hours per year.~~

~~2. Individuals who choose the consumer-directed model must have the capability to hire, train, and fire their own personal assistant or companion and supervise the assistant's or companion's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.~~

~~3. The individual, or if the individual is unable, then family/caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing assistants and companions. Specific employer duties include checking of references of personal assistants/companions, determining that personal assistants/companions meet basic qualifications, training assistants/companions, supervising the assistant's/companion's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual and the individual's family/caregiver, as appropriate, must have a back-up plan in case the assistant/companion does not show up for work as expected or terminates employment without prior notice.~~

~~4. Individuals choosing consumer-directed models of service delivery must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance, respite, or companion services. The CD services facilitator will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the ISP, providing training to the individual and the individual's family/caregiver, as appropriate, on his responsibilities as an employer, and providing ongoing support of the consumer-directed models of services. The CD services facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the assistant/companion. If an individual enrolled in consumer-directed services has a lapse in services facilitator for more than 90 consecutive days, the case manager must notify DMHMRSAS and the consumer directed services will be discontinued.~~

~~5. DMAS shall provide for fiscal agent services for consumer-directed personal assistance services, consumer-directed companion services, and consumer-directed respite services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle the responsibilities of employment taxes for the individual. 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.~~

~~B. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the CD services facilitator must meet the following qualifications:~~

~~1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have 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.~~

~~2. 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. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with persons with mental retardation. The 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 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:~~

~~a. Knowledge of:~~

~~(1) Types of functional limitations and health problems that may occur in persons with mental retardation, or persons with other disabilities, as well as strategies to reduce limitations and health problems;~~

~~(2) Physical assistance that may be required by people with mental retardation, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;~~

~~(3) Equipment and environmental modifications that may be required by people with mental retardation that reduce the need for human help and improve safety;~~

~~(4) Various long-term care program requirements, including nursing home and ICF/MR placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;~~

~~(5) MR waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;~~

~~(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;~~

~~(7) Interviewing techniques;~~

~~(8) 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 time sheets, and firing an assistant/companion;~~

~~(9) The principles of human behavior and interpersonal relationships; and~~

~~(10) General principles of record documentation.~~

~~b. Skills in:~~

~~(1) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;~~

~~(2) Assessing, supporting, observing, recording, and reporting behaviors;~~

~~(3) Identifying, developing, or providing services to individuals with mental retardation; 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 individuals 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; and~~

~~(6) Develop a rapport and communicate with persons of diverse cultural backgrounds.~~

~~3. If the CD services facilitator is not a 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. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the needs, assist in the development of the ISP with the individual and the individual's family/caregiver, as appropriate, and provide employee management training. The initial comprehensive home visit is done 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 chooses to receive. If an individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.~~

~~b. After the initial visit, the CD services facilitator will continue to monitor the companion, or personal assistant ISP quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 240 respite services hours, whichever comes first.~~

~~c. A face-to-face meeting with the individual must be conducted at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual.~~

~~5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual and the individual's family/caregiver, as appropriate, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical needs, and social needs.~~

~~6. The CD services facilitator must be available to the individual by telephone.~~

~~7. The CD services facilitator must submit a criminal record check pertaining to the assistant/companion on behalf of the individual and report findings of the criminal record check to the individual and the individual's family/caregiver, as appropriate, and the program's fiscal agent. If the individual is a minor, the assistant/companion must also be screened through the DSS Child Protective Services Central Registry. Assistants/companions will not be reimbursed for services provided to the individual effective the date that the criminal record check confirms~~

~~an assistant/companion has been found to have been convicted of a crime as described in § 37.2-416 of the Code of Virginia or if the assistant/companion has a confirmed record on the DSS Child Protective Services Central Registry. The criminal record check and DSS Child Protective Services Central Registry finding must be requested by the CD services facilitator within 15 calendar days of employment. The services facilitator must maintain evidence that a criminal record check was obtained and must make such evidence available for DMAS review.~~

~~8. The CD services facilitator shall review timesheets during the face-to-face visits or more often as needed to ensure that the number of ISP-approved hours is not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual to resolve discrepancies and must notify the fiscal agent.~~

~~9. The CD services facilitator must maintain a list of persons who are available to provide consumer-directed personal assistance, consumer-directed companion, or consumer-directed respite services.~~

~~10. The CD services facilitator must maintain records of each individual as described in 12VAC30-120-217, 12VAC30-120-223, and 12VAC30-120-233.~~

~~11. Upon the individual's request, the CD services facilitator shall provide the individual and the individual's family/caregiver, as appropriate, with a list of persons who can provide temporary assistance until the assistant/companion returns or the individual is able to select and hire a new personal assistant/companion. If an individual is consistently unable to hire and retain the employment of an assistant/companion to provide consumer-directed personal assistance, companion, or respite services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual and the individual's family/caregiver, as appropriate, other service options.~~

12VAC30-120-227. ~~Crisis stabilization services.~~ (Repealed.)

~~A. Crisis stabilization services involve direct interventions that provide temporary intensive services and support that avert emergency psychiatric hospitalization or institutional placement of persons with mental retardation who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services will include, as appropriate, neuro-psychiatric, psychiatric, psychological, and other functional 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 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 with planning and delivery of services and supports to enable the individual to remain in the community;~~

~~2. Train family/caregivers and service providers in positive behavioral 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 a 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/MR placement;~~

~~c. Immediate threat of loss of a community service due to a severe situational reaction; or~~

~~d. Causing harm to self or others.~~

~~C. Service units and service limitations. Crisis stabilization services may only be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional.~~

~~1. The unit for each component of the service is one hour. This service may only be authorized in 15-day increments but no more than 60 days in a calendar year may be used. 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, may only be authorized following a documented face-to-face reassessment conducted by a qualified mental retardation professional.~~

~~2. Crisis stabilization services may be provided directly in the following settings (examples below are not exclusive):~~

~~a. The home of an individual who lives with family, friends, or other primary caregiver or caregivers;~~

~~b. The home of an individual who lives independently or semi-independently to augment any current services and supports;~~

~~c. A community-based residential program to augment current services and supports;~~

~~d. A day program or setting to augment current services and supports; or~~

~~e. A respite care setting to augment current services and supports.~~

~~3. Crisis supervision is an optional component of crisis stabilization in which one-to-one supervision of the individual in crisis is 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.~~

~~4. Crisis stabilization services shall not be used for continuous long-term care. Room, 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 participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the following crisis stabilization provider qualifications apply:~~

~~1. Crisis stabilization services shall be provided by providers licensed by DMHMRSAS as a provider of outpatient services, residential, or supportive in-home residential services, or day support services. The provider must employ or utilize qualified mental retardation professionals, licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities to individuals with mental retardation who are experiencing serious psychiatric or behavioral problems. The qualified mental retardation professional shall have: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession;~~

~~2. To provide the crisis supervision component, providers must be licensed by DMHMRSAS as providers of residential services, supportive in-home residential services, or day support services;~~

~~3. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving crisis stabilization services. At a minimum, the record must contain the following:~~

~~a. Documentation of the face-to-face assessment and any reassessments completed by a qualified mental retardation professional;~~

~~b. An ISP that contains, at a minimum, the following elements:~~

~~(1) The individual's strengths, desired outcomes, required or desired supports;~~

~~(2) The individual's goals;~~

~~(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;~~

~~(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.~~

~~c. An ISP must be developed or revised and submitted to the case manager for submission to DMHMRSAS within 72 hours of the requested start date for authorization;~~

~~d. 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 ISP objectives; and~~

~~e. Documentation of qualifications of providers must be maintained for review by DMHMRSAS and DMAS staff.~~

12VAC30-120-229. ~~Day support services.~~ (Repealed.)

~~A. Service description. Day support services shall include a variety of training, assistance, support, and specialized supervision for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. These services are typically offered in a nonresidential setting that allows peer interactions and community and social integration.~~

~~B. Criteria. 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 allows an opportunity~~

~~for being productive and contributing members of communities.~~

~~C. Types of day support. The amount and type of day support included in the individual's service plan 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.~~

~~D. Levels of day support. There are two levels of day support, intensive and regular. 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. 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 and service limitations. Day support services are billed according to the DMAS fee schedule.~~

~~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. Noncenter-based day support services must be separate and distinguishable from either residential support services or personal assistance 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. Service providers are reimbursed only for the amount and level of day support services included in the individual's approved ISP based on the setting, intensity, and duration of the service to be delivered. This service shall be limited to 780 units, or its equivalent under the DMAS fee schedule, per CSP year. If this service is used in combination with prevocational and/or group supported employment services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per CSP year.~~

~~F. 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, day support providers need to meet additional requirements.~~

~~1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services.~~

~~2. In addition to licensing requirements, day support staff must also have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations. All providers of day support services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.~~

~~3. Required documentation in the individual's record. The provider 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 day support 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 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.~~

~~c. 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 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, or their equivalent under the DMAS fee schedule, provided.~~

~~d. Documentation indicating whether the services were center-based or noncenter-based.~~

~~e. Documentation regarding transportation. In instances where day support staff are required to ride with the individual to and from day support, the day support staff time can 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. If intensive day support services are requested, documentation indicating the specific supports and the reasons they are needed. For ongoing intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.~~

~~g. Documentation indicating that the ISP goals, objectives, and 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 ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.~~

~~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.~~

12VAC30-120-231. ~~Environmental modifications.~~ (Repealed.)

~~A. Service description. Environmental modifications shall be defined as those physical adaptations to the home or vehicle, required by the individual's CSP, that are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence 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 electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Modifications can be made to an automotive vehicle if it is the primary vehicle being used by the individual. Modifications may be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act.~~

~~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.~~

~~C. Service units and service limitations. Environmental modifications shall be available to individuals who are receiving at least one other waiver service in addition to targeted mental retardation case management. A maximum limit of $5,000 may be reimbursed per CSP year. Costs for environmental modifications shall not be carried over from CSP year to CSP year and must be prior authorized by DMHMRSAS for each CSP year. Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repairs, central air conditioning, etc., and are not of direct medical or remedial benefit to the individual. Also excluded are 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.~~

~~D. 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, environmental modifications must be provided in accordance with all applicable federal, state or local building codes and laws by contractors of the CSB/BHA or providers who have a participation agreement with DMAS who shall be reimbursed for the amount charged by said contractors. The following are provider documentation requirements:~~

~~1. An ISP that documents the need for the service, the process to obtain the service, and the time frame during which the services are to be provided. The ISP must include documentation of the reason that a rehabilitation engineer or specialist is needed, if one is to be involved;~~

~~2. Documentation of the time frame involved to complete the modification and the amount of services and supplies;~~

~~3. Any other relevant information regarding the modification;~~

~~4. Documentation of notification by the individual and the individual's family/caregiver, as appropriate, of satisfactory completion of the service; and~~

~~5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed.~~

12VAC30-120-233. ~~Personal assistance and respite services.~~ (Repealed.)

~~A. Service description. Services may be provided either through an agency-directed or consumer-directed model.~~

~~1. Personal assistance services are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. They 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 instrumental activities of daily living (IADLs). Personal assistance does 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 does 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 are supports for that which is normally provided by the family or other unpaid primary caregiver of an individual. These services are furnished on a short-term basis because of the absence or need for relief of those unpaid caregivers normally providing the care for the individuals.

B. Criteria.

1. In order to qualify for personal assistance services, the individual must demonstrate a need for assistance with activities of daily living, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

2. Respite services may only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual.

C. Service units and service limitations.

1. The unit of service is one hour.

2. Each individual must have a back-up plan in case the personal assistant does not show up for work as expected or terminates employment without prior notice.

3. Personal assistance is not available to individuals: (i) who receive congregate residential services or live in assisted living facilities; (ii) who would benefit from personal assistance training and skill development; or (iii) who receive comparable services provided through another program or service.

4. Respite services shall not be provided to relieve group home or assisted living facility staff where residential care is provided in shifts. Respite services shall not be provided by adult foster care providers for an individual residing in that home. Training of the individual is not provided with respite services.

5. Effective July 1, 2011, respite services shall be limited to a maximum of 480 hours per year. Individuals who are receiving services through both the agency-directed and consumer-directed model cannot exceed 480 hours per year combined.

6. Within the limits established herein, the hours authorized are based on individual need. No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the assistant.

D. 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, personal assistance and respite providers must meet additional provider requirements:

1. Services shall be provided by:

a. For the agency-directed model, an enrolled DMAS personal care/respite care provider or by a DMHMRSAS-licensed residential services provider. In addition, respite services may be provided by a DMHMRSAS-licensed respite services provider or a DSS-approved foster care home for children or adult foster home provider. All personal assistants must pass an objective standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

b. For consumer-directed model, a services facilitator meeting the requirements found in 12VAC30-120-225.

2. For DMHMRSAS-licensed residential or respite services providers, a residential or respite supervisor will provide ongoing supervision of all assistants.

3. For DMAS-enrolled personal care/respite care providers, the provider must employ or subcontract with and directly supervise a RN or a LPN who will provide ongoing supervision of all assistants. The supervising RN or LPN must be currently licensed to practice nursing 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/MR or nursing facility.

4. The supervisor or services facilitator must make a home visit to conduct an initial assessment prior to the start of services for all individuals requesting personal assistance or respite services. The supervisor or services facilitator must also perform any subsequent reassessments or changes to the supporting documentation.

5. The supervisor or services facilitator must make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 to 90 days under the agency-directed model and semi-annually (every six months) under the consumer-directed model 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 is not required to conduct a supervisory visit every 30 to 90 days. Instead, the supervisor or services facilitator must conduct the initial home visit with the respite assistant immediately

preceding the start of services and make a second home visit within the respite period.

b. When respite services are routine in nature 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 must document supervision of respite services separately. For this purpose, the same individual record can be used with a separate section for respite services documentation.

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

7. Qualification of assistants.

a. The assistant must:

(1) Be 18 years of age or older and possess a valid social security number;

(2) Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills; and

(3) Have the required skills to perform services as specified in the individual's ISP.

b. Additional requirements for DMAS-enrolled personal care/respite care providers.

(1) Assistants must complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

(a) Registration as a certified nurse aide;

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistance, or home health aide;

(c) Completion of provider-offered training, which is consistent with the basic course outline approved by DMAS; and

(2) Assistants must 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.

c. Additional requirements for the consumer-directed option. The assistant must:

(1) Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The assistant will not be compensated for services provided to the individual if either of these records checks verifies the assistant has been convicted of crimes described in § 37.2-416 of the Code of Virginia or if the assistant has a founded complaint confirmed by the DSS Child Protective Services Central Registry;

(2) Be willing to attend training at the individual and the individual's family/caregiver, as appropriate, request;

(3) Understand and agree to comply with the DMAS MR Waiver requirements; and

(4) Receive an annual tuberculosis (TB) screening.

8. Assistants may not be the parents of individuals who are minors, or the individuals' spouses. Payment may 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 service. Family members who are approved to be reimbursed for providing this service must meet the assistant qualifications.

9. Provider inability to render services and substitution of assistants (agency-directed model).

a. When an assistant is absent, the provider is 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 to be less than two weeks in duration, or transfer the individual's services to another provider. The provider that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization 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 case manager so that the case manager may find another available provider of the individual's choice.

c. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures must apply:

(1) The preauthorized provider must provide the supervision for the substitute assistant;

(2) The provider of the substitute assistant must send a copy of the assistant's daily documentation signed by the individual and the individual's family/caregiver, as appropriate, on his behalf and the assistant to the provider having the authorization; and

~~(3) The preauthorized provider must bill DMAS for services rendered by the substitute assistant.~~

~~d. If a provider secures a substitute assistant, the provider agency is 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 are responsible for negotiating the financial arrangements of paying the substitute assistant.~~

~~10. Required documentation in the individual's record. The provider must maintain records regarding each individual receiving services. At a minimum these records must contain:~~

~~a. An initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated;~~

~~b. An ISP, that contains, at a minimum, the following elements:~~

~~(1) The individual's strengths, desired outcomes, required or desired supports;~~

~~(2) The individual's goals and objectives to meet the above identified outcomes;~~

~~(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives; and~~

~~(4) For the agency-directed model, the provider staff responsible for the overall coordination and integration of the services specified in the ISP.~~

~~c. The ISP goals, objectives, and activities must be reviewed by the supervisor or services facilitator quarterly for personal assistance only, annually, and more often as needed modified as appropriate and results of these reviews 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.~~

~~d. Dated notes of any contacts with the assistant, individual and the individual's family/caregiver, as appropriate, during supervisory or services facilitator visits to the individual's home. The written summary of the supervision or services facilitation visits must include:~~

~~(1) Whether services continue to be appropriate and whether the ISP is adequate to meet the need or if changes are indicated in the ISP;~~

~~(2) Any suspected abuse, neglect, or exploitation and to whom it was reported;~~

~~(3) Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;~~

~~(4) The individual's satisfaction with the service;~~

~~(5) Any hospitalization or change in medical condition or functioning status;~~

~~(6) Other services received and their amount; and~~

~~(7) The presence or absence of the assistant in the home during the supervisor's visit.~~

~~e. All correspondence to the individual and the individual's family/caregiver, as appropriate, case manager, DMAS, and DMHMRSAS;~~

~~f. Reassessments and any changes to supporting documentation made during the provision of services;~~

~~g. Contacts made with the individual, family/caregivers, physicians, formal and informal service providers, and all professionals concerning the individual;~~

~~h. Copy of the most recently completed DMAS-122 form. The provider or services facilitator must clearly document efforts to obtain the completed DMAS-122 form from the case manager.~~

~~i. For the agency-directed model, the assistant record must contain:~~

~~(1) The specific services delivered to the individual by the assistant, dated the day of service delivery, and the individual's responses;~~

~~(2) The assistant's arrival and departure times;~~

~~(3) The assistant'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 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.~~

~~j. For individuals receiving personal assistance and respite services in a congregate residential setting, because services that are training in nature are currently or no longer appropriate or desired, the record must contain:~~

~~(1) The specific services delivered to the individual, dated the day services were provided, the number of hours as outlined in the ISP, the individual's responses, and observations of the individual's physical and emotional condition; and~~

~~(2) At a minimum, monthly verification by the residential supervisor of the services and hours and quarterly verification as outlined in 12VAC30-120-241.~~

~~k. For the consumer-directed model, the assistant record must contain:~~

~~(1) Documentation of all training provided to the assistants on behalf of the individual and the individual's family/caregiver, as appropriate;~~

~~(2) Documentation of all employee management training provided to the individual and the individual's family/caregiver, as appropriate, including the individual and the individual's family/caregiver, as appropriate, receipt of training on their responsibility for the accuracy of the assistant's timesheets;~~

~~(3) All documents signed by the individual and the individual's family/caregiver, as appropriate, that acknowledge the responsibilities as the employer.~~

12VAC30-120-235. ~~Personal Emergency Response System (PERS).~~ (Repealed.)

~~A. Service description. PERS is a service which 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.~~

~~B. Criteria. PERS can be authorized when there is no one else in the home who is competent or continuously available to call for help in an emergency.~~

~~C. Service units and service limitations.~~

~~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 the 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.~~

~~D. 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, PERS providers must also meet the following qualifications:~~

~~1. A PERS provider is a personal assistance agency, a durable medical equipment provider, a hospital, a licensed home health provider, 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 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 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 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 a PERS individual's functioning telephone line 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 a data record for each PERS individual at no additional cost to DMAS. The record must document the following:~~

~~a. Delivery date and installation date of the PERS;~~

~~b. Individual or family/caregiver signature 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, 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.~~

8. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

9. 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.

10. A PERS provider must furnish education, data, and ongoing assistance to DMAS, DMHMRSAS and case managers to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the individual, family/caregiver, and responders in the use of the PERS service.

11. The emergency response activator must 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 resetting the system in the event it cannot get its signal accepted at the response center.

12. 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 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.

13. 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.

14. 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. This excludes test signals or activations made in error.

15. The PERS provider is prohibited from performing any type of direct marketing activities to Medicaid recipients.

16. The provider must obtain and keep on file a 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.

12VAC30-120-237. 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 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). Activities included in this service are not primarily directed at teaching specific job skills but at underlying habilitative 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 of paid employment that may be offered in a variety of community settings.

C. Service units and service limitations. Billing is in accordance with the DMAS fee schedule.

1. This service is limited to 780 units, or its equivalent under the DMAS fee schedule, per CSP year. If this service is used in combination with day support and /or group-supported employment services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per CSP year.

~~2. Prevocational services can be provided in center- or noncenter-based settings. Center-based means services are provided primarily at one location/building and noncenter-based means services are provided primarily in community settings. Both center-based or noncenter-based prevocational services may be provided at either regular or intensive levels.~~

~~3. Prevocational services can be provided at either a regular or intensive level. 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 (toileting, feeding, etc); (ii) have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish 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.~~

~~4. There must 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, documentation is required only for lack of DRS funding. When services are provided through these sources, the ISP shall not authorize them as a waiver expenditure.~~

~~5. Prevocational services can only be provided when the individual's compensation is less than 50% of the minimum wage.~~

~~D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, prevocational providers must also meet the following qualifications:~~

~~1. 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. Providers must ensure and document that persons providing prevocational services have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations. All providers of prevocational services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.~~

~~3. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving prevocational services. At a minimum, the records must contain the following:~~

~~a. A functional assessment conducted by the provider to evaluate each individual in the prevocational environment and community settings.~~

~~b. An ISP, which 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 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;~~

~~(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.~~

~~c. Documentation indicating that the ISP goals, objectives, and activities have been reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and that the results of these reviews have been 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 and the individual's family/caregiver, as appropriate.~~

~~d. Documentation confirming the individual's attendance, amount of time spent in services, and 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, or their equivalent under the DMAS fee schedule, provided.~~

~~e. Documentation indicating whether the services were center-based or noncenter-based.~~

~~f. Documentation regarding transportation. In instances where prevocational staff are required to ride with the individual to and from prevocational services, the prevocational staff time can be billed for prevocational services, provided that 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 spent in the prevocational services for that day.

g. If intensive prevocational services are requested, documentation indicating the specific supports and the reasons they are needed. For ongoing intensive prevocational services, there must be clear documentation of the ongoing needs and associated staff supports.

h. Documentation indicating 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).

i. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-241. Residential support services. (Repealed.)

A. Service description. Residential support services consist of training, assistance or specialized supervision provided primarily in an individual's home or in a licensed or approved residence to 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 included in the individual's approved ISP. Residential support services shall be authorized in the ISP only when the individual requires these services and these services exceed the services included in the individual's room and board arrangements for individuals residing in group homes, or, for other individuals, if these services exceed supports provided by the family/caregiver. Services will not be routinely reimbursed for a continuous 24-hour period.

B. Criteria.

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

2. In order to qualify for this service in a congregate setting, the individual shall have a demonstrated need for continuous training, assistance, and supervision for up to 24 hours per day.

3. A functional assessment must be conducted to evaluate each individual in his home environment and community settings.

4. The residential support ISP must 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.

C. Service units and service limitations. Total billing cannot exceed the authorized amount in the ISP. The provider must maintain documentation of the date and times that services were provided, and specific circumstances that prevented provision of all of the scheduled services.

1. This service must be provided on an individual-specific basis according to the ISP and service setting requirements;

2. Congregate residential support services may not be provided to any individual who receives personal assistance services under the MR Waiver or other residential services that provide a comparable level of care. Respite services may be provided in conjunction with in-home residential support services to unpaid caregivers.

3. Room, 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 for the family/caregiver with whom the individual lives; and

5. Medicaid reimbursement is available only for residential support services provided when the individual is present and when a qualified provider is providing the services.

D. Provider requirements.

1. 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, the provider of residential services must have the appropriate DMHMRSAS residential license.

2. Residential support services may also be provided in adult foster care homes approved by local DSS offices pursuant to state DSS regulations.

3. In addition to licensing requirements, persons providing residential support services are required to participate in training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for individuals with mental retardation and functional limitations. All providers of residential support 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 residential support services. At a minimum these records must contain the following:

~~a. A functional assessment conducted by the provider to evaluate each individual in the residential environment and community settings.~~

~~b. An ISP containing the following elements:~~

~~(1) The individual's strengths, desired outcomes, required or desired supports, or both, and training needs;~~

~~(2) The individual's goals and measurable objectives to meet the above identified outcomes;~~

~~(3) The services to be rendered and the schedule of services to accomplish the above goals, objectives, and desired outcomes;~~

~~(4) A timetable for the accomplishment of the individual's goals and objectives;~~

~~(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.~~

~~c. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews 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 and the individual's family/caregiver, as appropriate.~~

~~d. Documentation must confirm attendance, the 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.~~

~~e. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.~~

12VAC30-120-245. ~~Skilled nursing services.~~ (Repealed.)

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

~~B. Criteria. In order to qualify for these services, the individual shall 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 CSP must indicate that the service is necessary in order to prevent institutionalization and is not available under the State Plan for Medical Assistance.~~

~~C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units. The services must be explicitly detailed in an ISP and must be specifically ordered by a physician as medically necessary to prevent institutionalization.~~

~~D. 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, participating skilled nursing providers must meet the following qualifications:~~

~~1. Skilled nursing services shall be provided by either a DMAS-enrolled home care organization provider or home health provider, or by a registered nurse licensed by the Commonwealth or licensed practical nurse licensed by the Commonwealth (under the supervision of a registered nurse licensed by the Commonwealth), contracted or employed by DMHMRSAS-licensed day support, respite, or residential providers.~~

~~2. Skilled nursing services providers may not be the parents of individuals who are minors, or the individual's spouse. Payment may 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 provide skilled nursing services must meet the skilled nursing requirements.~~

~~3. Foster care providers may not be the skilled nursing services providers for the same individuals to whom they provide foster care.~~

~~4. Required documentation. The provider must maintain a record that contains:~~

~~a. An ISP that contains, at a minimum, the following elements:~~

~~(1) The individual's strengths, desired outcomes, required or desired supports;~~

~~(2) The individual's goals;~~

~~(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;~~

~~(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 ISP;~~

~~b. Documentation of any training of family/caregivers or staff, or both, to be provided, including the person or~~

~~persons being trained and the content of the training, consistent with the Nurse Practice Act;~~

~~c. Documentation of the determination of medical necessity by a physician prior to services being rendered;~~

~~d. Documentation of nursing license/qualifications of providers;~~

~~e. Documentation indicating the dates and times of nursing services and the amount and type of service or training provided;~~

~~f. Documentation that the ISP was reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews 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.~~

~~g. Documentation that the ISP has been reviewed by a physician within 30 days of initiation of services, when any changes are made to the ISP, and also reviewed and approved annually by a physician; and~~

~~h. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.~~

12VAC30-120-247. ~~Supported employment services.~~ (Repealed.)

~~A. Service description.~~

~~1. 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.~~

~~2. 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.~~

~~3. 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. Only job development tasks that specifically include the individual are allowable job search activities under the MR waiver supported employment and only after determining this service is not available from DRS.~~

~~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. A functional assessment must be conducted to evaluate the individual in his work environment and related community settings.~~

~~4. 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 based on the intensity and duration of the service delivered.~~

~~C. Service units and service limitations.~~

~~1. Supported employment for individual job placement is provided in one-hour units. This service is limited to 40 hours per week.~~

~~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.~~

~~This service is limited to 780 units, or its equivalent under the DMAS fee schedule, per CSP year. If this service is 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 CSP year.~~

~~3. 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.~~

~~D. 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, supported employment provider qualifications include:~~

~~1. Group and agency-directed individual supported employment shall be provided only by agencies that are DRS vendors of supported employment services;~~

~~2. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving supported employment services. At a minimum, the records must contain the following:~~

~~a. A functional assessment conducted by the provider to evaluate each individual in the supported employment environment and related community settings.~~

~~b. Documentation indicating individual ineligibility for supported employment services through DRS or IDEA. If the individual is not eligible through IDEA, documentation is required only for the lack of DRS funding;~~

~~c. An ISP that contains, at a minimum, the following elements:~~

~~(1) The individual's strengths, desired outcomes, required/desired supports and training needs;~~

~~(2) The individual's goals and, for a training goal, 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;~~

~~(5) The estimated duration of the individual's needs for services; and~~

~~(6) Provider staff responsible for the overall coordination and integration of the services specified in the plan.~~

~~d. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and the results of these reviews 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 and the individual's family/caregiver, as appropriate.~~

~~e. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time can be billed for 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 for supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.~~

~~f. There must be a copy of the completed DMAS-122 in the record. Providers must clearly document efforts to obtain the DMAS-122 form from the case manager.~~

12VAC30-120-249. ~~Therapeutic consultation.~~ (Repealed.)

~~A. Service description. Therapeutic consultation provides expertise, training and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are (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, is based on the individual's CSP, and provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their ability to function in the community. Therapeutic consultation services may be provided in the individual's home, and in appropriate community settings and are intended to facilitate implementation of the individual's desired outcomes as identified in his CSP.~~

~~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 CSP cannot be implemented effectively and efficiently without such consultation from this service.~~

~~1. The individual's therapeutic consultation ISP 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 ISP effectively.~~

~~2. Therapeutic consultation services may not include direct therapy provided to waiver individuals or monitoring activities, and may not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.~~

~~C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the ISP. 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. Only behavioral consultation may be offered in the absence of any other waiver service when the consultation is determined to be necessary to prevent institutionalization.~~

~~D. 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, professionals rendering therapeutic consultation services shall meet all applicable state or national licensure, endorsement 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 professionals' work experience, education, and demonstrated knowledge, skills, and abilities.~~

~~The following documentation is required for therapeutic consultation:~~

~~1. An ISP, that contains at a minimum, the following elements:~~

~~a. Identifying information:~~

~~b. Targeted objectives, time frames, and expected outcomes; and~~

~~c. Specific consultation activities.~~

~~2. A written support plan detailing the recommended interventions or support strategies for providers and family/caregivers to use to better support the individual in the service.~~

~~3. Ongoing documentation of consultative services rendered in the form of contact-by-contact or monthly notes that identify each contact.~~

~~4. If the consultation service extends beyond the one year, the ISP must be reviewed by the provider with the individual receiving the services and the case manager, and this written review must be submitted to the case manager, at least annually, or more as needed. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and are to be forwarded to the case manager. Any changes to the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.~~

~~5. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain a copy of the completed DMAS-122 from the case manager.~~

~~6. A final disposition summary that must be forwarded to the case manager within 30 days following the end of this service.~~

Part IV
Mental Retardation/Intellectual Disability Waiver

Article 1
Definitions and General Requirements

12VAC30-120-1000. Definitions.

"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.

"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.

"ADA" means the American with Disabilities Act pursuant to 42 USC § 12101 et seq.

"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 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 § 37.2-100 of the Code of Virginia that plans, provides, and evaluates mental health, mental retardation/intellectual disability (MR/ID), and substance abuse services in the locality that it serves.

"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.

"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 possessing a combination of MR/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.

"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, MR/ID, and substance abuse services in the jurisdiction or jurisdictions it serves.

"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 hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature.

"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" 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 MR/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, are 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 persons with MR/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.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DBHDS staff" means persons employed by or contracted with DBHDS.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by or contracted with DMAS.

"DRS" means the Department of Rehabilitative Services.

"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.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer directed model. The EOR may be the waiver individual, or a family member, caregiver or another 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 MR/ID Waiver and DBHDS has verified the availability of a MR/ID Waiver slot for that individual. Financial eligibility determinations and enrollment in Medicaid are set out in 12VAC30-120-1010.

"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, 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 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 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.

"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.

"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 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 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.

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual Support Plan" means a comprehensive plan that sets out the supports and actions to be taken during the year by each service provider, as detailed in the provider's Plan for Supports, to achieve desired outcomes. The Individual Support Plan shall be developed by the individual, the individual's family/caregiver, as appropriate, other service providers such as the case manager, and other interested parties chosen by the individual, and shall contain 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.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"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 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.

"ISAR" means the Individual Service Authorization Request and is the DMAS form used by providers to request prior authorization for MR/ID Waiver services.

"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.

"Medicaid Long-Term Care Communication Form" or "DMAS-225" means the form used by the case manager to report, as required in agency's guidance documents, 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.

"Mental retardation/intellectual disability" or "MR/ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD). For the purposes of this waiver and these regulations, "MR" and "ID" shall be synonymous terms.

"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 services until all required information is received by DBHDS.

"Person-centered planning" means a fundamental process that focuses 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 with ADLs, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

"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 a waiver individual wants to maintain, change, or improve in his life and shall be completed by the waiver individual and another person, such as his 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 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 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 waiver individual, if provided, shall be less than 50% of the minimum wage.

"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 providing such care.

"Prior authorization" means the process of approving by either DMAS or its designated prior authorization contractor, for the purpose of DMAS' reimbursement, the service for the individual before it is rendered.

"Qualified mental retardation professional" or "QMRP" for the purposes of the MR/ID Waiver means a professional possessing (i) at least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities; (ii) at least a bachelor's degree in a human services field including, but not necessarily limited to, sociology, social work, special education, rehabilitation counseling, or psychology, or a bachelor's degree in another field in addition to an advanced degree in a human services field; and (iii) the required, as appropriate, Virginia or national license, registration, or certification in accordance with his professional standards.

"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.

"Risk assessment" means an assessment that is completed by the 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 MR/ID 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.

"Safety supports" means specialized assistance that is required to assure the health and welfare of an individual.

"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 ensuring 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.

"Significant change" means, but shall not be limited to, a change in an individual's condition that is expected to last longer than 30 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.

"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 waiver individual.

"Slot" means an opening or vacancy in waiver services for an individual.

"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.

"Supports" means paid and nonpaid assistance that promotes the accomplishment of an individual's desired outcomes. There shall be three types of supports: (i) routine supports that assist the individual in daily activities; (ii) skill building supports that help the individual gain new abilities; and (iii) safety supports that are required to assure the individual's health and safety.

"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 MR/ID to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"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 waiver individual.

"Transition services" means set-up expenses as defined in 12VAC30-120-2010.

"VDSS" means the Virginia Department of Social Services.

12VAC30-120-1005. Waiver description and legal authority.

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/MR, 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 MR/ID Waiver in accordance with the interagency agreement between DMAS and DBHDS.

D. 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/MR:

1. Individuals with MR/ID; or

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 MR/ID to continue to receive home and community-based waiver services specifically under this program.

MR/ID Waiver individuals who attain the age of six years of age, who are determined not to have a diagnosis of MR/ID, and who meet all Individual and Family Developmental Disability Support (IFDDS) Waiver eligibility criteria, shall be eligible for transfer to the IFDDS Waiver for the period of time up to their seventh birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These individuals transferring from the MR/ID Waiver will be assigned a slot in the IFDDS Waiver, subject to the approval of the slot by CMS. 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 MR/ID case manager shall provide the family with a list of IFDDS Waiver case managers. The MR/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 MR/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, consistent with DBHDS guidance policies, the MR/ID slot to another individual on the waiting list. If there is no IFDDS Waiver slot available for this child, then the child shall be placed on the IFDDS Waiver's waiting list. Such waiver individuals shall be dis-enrolled from the MR/ID Waiver.

E. MR/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/MR, or inpatient rehabilitation facility. Individuals with MR/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.

F. An individual shall not be simultaneously enrolled in more than one waiver program.

G. 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.

H. No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed.

12VAC30-120-1010. Individual eligibility requirements.

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(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 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 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 MR/ID who seek these waiver services:

a. Individuals qualifying for MR/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 MR/ID or (ii) a child younger than six years of age being at developmental risk of significant functional limitations in major life activities;

b. Individuals qualifying for MR/ID Waiver services shall meet the ICF/MR level-of-care criteria;

c. The Individual Support Plan and services that are delivered shall be consistent with the Medicaid definition of each service; and

d. Services shall be recommended by the case manager based on a current assessment using a DBHDS-approved assessment instrument, as specified in DBHDS and DMAS guidance documents, by demonstrating need for each specific service.

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/MR, home and community-based waiver services shall be considered only for individuals who are eligible for admission to an ICF/MR due to their diagnoses of MR/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, MR/ID Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR, or to promote exiting from either an ICF/MR 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/MR 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/MR 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 MR/ID Waiver services or ICF/MR placement.

4. The case manager shall send the appropriate forms to DBHDS to enroll the individual in the MR/ID Waiver or, if no slot is available, to place the individual on the waiting list. DBHDS shall only enroll the individual if a slot is available. If no slot is available, then the individual's name shall be placed on either the urgent or non-urgent statewide waiting list, consistent with criteria established in this waiver in 12VAC30-120-1088, until such time as a slot becomes available. Once notification has been received from DBHDS that the individual has been placed on either the urgent or non-urgent 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 MR/ID Waiver services, has determined that a slot is available, and that the individual has chosen MR/ID Waiver services, the case manager shall submit enrollment information to DBHDS to

confirm level-of-care eligibility and the availability of a slot.

2. Once the individual has been enrolled by DBHDS, the case manager will submit a DMAS-225 along with a written confirmation from DBHDS 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 and written confirmation of enrollment from DBHDS, 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 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 MR/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.

4. The individual or case manager shall contact chosen service providers so that services can be initiated within 30 days of receipt of enrollment confirmation from DBHDS. 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 prior authorization. Only MR/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 periodically 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 EOR, the case manager shall forward a copy of the DMAS-225 form to the consumer-directed fiscal/employer agent and the EOR.

6. The case manager shall submit the results of the comprehensive assessment and a recommendation to DBHDS staff for final determination of ICF/MR 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 prior authorization is required.

7. MR/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 MR/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/MR the cost of which would be reimbursed under the Plan; and

c. The contents of the Plans for Support shall be 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 MR/ID Waiver.

9. If services are not initiated by the provider within 30 days of receipt of enrollment confirmation from DBHDS, 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 a waiver 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 case manager shall submit written 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 that individual. DBHDS shall provide a written response to the case manager 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 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 MR/ID Waiver individuals 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 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 its approved substitute form.

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 MR/ID Waiver individuals residing in VDSS-licensed assisted living facilities or approved adult foster care homes. Case managers shall conduct a minimum of quarterly on-site home visits to individuals receiving MR/ID Waiver services who also reside in all DBHDS-licensed sponsored residential homes.

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

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

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

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

2. Each waiver individual's need 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. Waiver individuals 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. A waiver individual shall not receive consumer-directed services if at least one of the following conditions exists:

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

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

(c) The waiver individual 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 waiver individual 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 waiver individual when any of the following conditions occur:

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

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

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

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

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

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

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

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

6. Coordination of waiver services with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid benefit. When the definition of this waiver's service is the same as that for EPSDT, then reimbursement for the waiver service shall first be made through the Medicaid EPSDT benefit.

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

1. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for equipment or

modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. AT shall be covered in the least expensive, most cost-effective manner.

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

a. Effective July 1, 2011, 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 $3,000 per calendar year for individuals regardless of waiver for which AT is approved. Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of calendar year 2011 (under the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of calendar year 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period. 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. Medical equipment and supplies required for individuals under age 21 that are covered both under the State Plan for Medical Assistance and outside the State Plan shall be furnished through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

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

6. 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.

7. AT providers shall not be the spouse or parents of the waiver individual.

C. Companion (both consumer-directed and agency-directed) services. Service description. These services provide nonmedical care, socialization, or support to an adult (ages 18 or older). Companions may assist or support the waiver individual 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 by the waiver individual 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 purely be 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 waiver individual shall have demonstrated a need for assistance with IADLs, light housekeeping (such as cleaning the bathroom used by the waiver 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 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,

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 waiver individuals who receive congregate residential services. These services shall be available when waiver individuals 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 MR/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/MR placement; (iii) immediate threat of loss of a community service due to a severe situational reaction; or (iv) causing harm to self or others.

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

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

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

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

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

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

4. Crisis supervision shall be an optional component of crisis stabilization in which one-to-one supervision of the individual who is in crisis shall be provided by agency staff in order to ensure the safety of the individual and others in the environment. Crisis supervision may be provided as a component of crisis stabilization only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided one-to-one and face-to-face with the individual. Crisis supervision, if provided as a part of this service, shall be separately billed in hourly service units.

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

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

E. Day support services. Service description. These services shall include skill-building, supports, and safety supports for the acquisition, retention, or improvement of self-help, socialization, community integration, and adaptive skills. These services shall be typically offered in a nonresidential

setting that provides opportunities for peer interactions, community integration, and enhancement of social networks. There shall be two levels of this service: (i) intensive and (ii) regular.

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

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

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

4. Service units and service limitations.

a. This service shall be limited to 780 unit 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 seconds. 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 those physical adaptations to the waiver individual's primary home or primary vehicle that shall be required by the waiver 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 and without which the individual would require institutionalization. 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. 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.

1. In order to qualify for these services, the waiver individual 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 waiver individual and shall be completed within the Plan of Support year consistent with such plan's requirements.

b. Effective July 1, 2011, 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 $3,000 per calendar year for individuals regardless of waiver for which EM is approved. Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of calendar year 2011 (under the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of calendar year 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period. 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 who are receiving at least one other waiver service in addition to MR/ID targeted case management pursuant to 12VAC30-50-450. 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 waiver individual.

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 waiver individual, 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 and family/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 waiver 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 waiver individual 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 waiver individual.

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

1. In order to qualify for prevocational services, the waiver individual 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 unit blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. 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 unit 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 seconds.

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.

4. 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.

5. 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. Residential support services shall not 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.

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 waiver individual who receives personal assistance services under the MR/ID Waiver or other residential services that provide a comparable level of care as described in the agency's guidance documents. Residential support services shall be permitted to be provided to waiver individuals in conjunction with respite services for unpaid caregivers;

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

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

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

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

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

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

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, in order to avoid institutionalization of the individual, who have an unpaid primary caregiver or caregivers who require temporary relief. Such need for relief may be either episodic or intermittent.

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 year, to be prior authorized in six-month increments not to exceed 240 hours per six months. 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 do not use all of their allowed respite hours in the first six month-prior authorization period shall not be permitted to carry over any unused portion of hours to the second prior authorization period. 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 and family/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. Skill development shall not be provided with respite services.

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 respite assistant.

5. Consumer directed respite services shall meet the same standards as agency-directed respite services for service limits, authorizations, provider restrictions.

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

1. Services facilitators shall train waiver individuals, 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 be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the Plan for Supports, providing management training for the individual or the EOR, as appropriate, on his responsibilities as employers, and providing ongoing support of the CD model of services. The prior 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 using DMAS' agency guidance documents. 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.

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 100 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 described in DMAS' guidance documents.

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, as set out in the agency's guidance documents, 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. 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 waiver individual, the individual's case manager, a direct service provider, the individual's spouse, a parent of the individual who is a minor child, or a family/caregiver who is employing the assistant/companion.

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

13. Should the assistant 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.

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 waiver individual, or if the individual is unable, the family/caregiver, 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 the individual chooses services facilitation. For the individual not selecting SF, 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. A waiver individual who is younger than 18 years of age shall be required to have someone function in the capacity of an EOR.

c. Specific employer duties shall include checking references of assistants, determining that assistants meet specified qualifications, training the assistants, supervising assistants' performance, and submitting complete and accurate timesheets to the fiscal/employer agent on a consistent and timely basis.

d. Once the individual is authorized for CD services, the individual or the EOR shall successfully complete management training conducted by the services facilitator using DMAS guidance documents before the individual may hire an assistant for Medicaid reimbursement.

M. Skilled nursing services. Service description. These services shall be provided for waiver individuals 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 waiver 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 waiver individual 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 to be rendered by a registered nurse or licensed practical nurse as defined in 12VAC30-120-1000 and shall be provided in hourly 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 to prevent institutionalization.

N. Supported employment services. Service description. These services shall consist of intensive, ongoing supports that enable individuals to be employed in a regular 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. It is especially designed for individuals with developmental disabilities, including individuals with MR/ID, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential (i.e., 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 intermittent 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 waiver individual is in the supported employment situation.

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

3. Criteria.

a. Only job development tasks that specifically include the individual shall be allowable job search activities under the MR/ID waiver supported employment service and DMAS shall cover this service only after determining that this service is not available from DRS for this waiver individual.

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 unit 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 seconds. 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 waiver individual. The specialty areas shall be (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services shall be based on the waiver 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) and shall be 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 waiver individuals or monitoring activities 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 to prevent institutionalization.

P. Transition services. Transition services, as defined at 12VAC30-120-2000 and 12VAC30-120-2010, provide for set-up expenses for qualifying applicants. The MR/ID case manager shall coordinate with the discharge planner to ensure that MR/ID Waiver eligibility criteria shall be met.

1. Transition services shall be prior authorized by DMAS or its designated agent in order for reimbursement to occur.

2. For the purposes of transition funding, an institution means an ICF/MR, as defined at 42 CFR 435.1009, long stay hospital, or nursing facility.

12VAC30-120-1040. General requirements for participating providers.

A. Requests for participation shall be screened by DMAS or its designated contractor to determine whether the provider applicant meets the basic requirements for provider participation.

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, licensure and certification requirements 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 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 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@dmas.virginia.gov;

2. Immediately notify DMAS and DBHDS, in writing, of any change in the information that the provider previously submitted 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; 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 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 the 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 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 from first knowledge report 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 herein defined, within 15 days from the date of employment. If the waiver individual to be served is a minor child, perform a search of the VDSS Child Protective Services Central Registry. The assistant or companion shall not be compensated for services provided to the waiver individual 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 regardless of capacity. The personal assistant or companion shall not be reimbursed by DMAS for services provided to the waiver individual 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 waiver individual and family/caregiver, 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 to Medicaid recipients; and

19. Adhere to the provider participation agreement and the DMAS provider service 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.

D. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS' policies and periodically re-certify 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 and 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 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.

F. Providers shall use the required forms to document services, for purposes of reimbursement, to waiver individuals. 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, or its required successor form. Such forms shall be further described and discussed in the agency's guidance documents for this waiver program.

1. The Supports Intensity Scale form's use shall be phased-in across all CSBs/BHAs with completion effective by July 2012. During the phase-in process, CSBs/BHAs may use alternative assessment forms with the approval of DBHDS.

2. This provision for the phase-in process of the use of the SIS shall sunset effective July 1, 2012, except if otherwise noted in agency guidance documents.

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 waiver individual/employer who is receiving consumer-directed services.

1. The fiscal employer/agent shall be responsible for administering payroll services on behalf of the waiver individual 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 waiver individuals;

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 waiver 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 a waiver 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 waiver individual 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 waiver 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 working days of receipt of the request for change.

2. The waiver individual 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 waiver individual within 10 business days of the decision.

3. In a nonemergency situation, when a participating provider determines that services to a waiver individual 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 waiver individual shall not be eligible for appeal rights in this situation and may pursue services from another provider.

4. In an emergency situation when the health, safety, and welfare of the waiver individual, 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 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 when the individual's health, safety, and 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.

12VAC30-120-1060. Participation standards for provision of services; providers' requirements.

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, its approved alternative form during the phase in period, or its successor form as specified in DBHDS guidance documents.

2. A Plan for Supports containing, at a minimum, the following elements:

(a) The waiver individual's strengths, desired outcomes, required or desired supports or both, and skill-building needs;

(b) The waiver 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 waiver individual's desired outcomes and support activities;

(e) The estimated duration of the waiver 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 the individual 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 prior authorization or the 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 or its required successor form as specified in DBHDS guidance documents) 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 the individual and the individual's family/caregiver, as appropriate.

4. The companion services supervisor or CD services facilitator, as required by 12VAC30-120-1060, shall document in the waiver 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; and

6. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

C. The required documentation for assistive technology, environmental modifications (EM), and Personal Emergency Response Systems (PERS) shall be as follows:

1. The appropriate Individualized Service Authorization Request (ISAR) form, 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/ISAR shall include justification and explanation that a rehabilitation engineer is needed, if one is required. The ISAR shall be submitted to the state-designated agency or its contractor in order for prior 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 general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, AT shall be provided by DMAS-enrolled DME providers or DMAS-enrolled CSBs/BHAs with a MR/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 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 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 waiver 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 defined in the DMAS MR/ID Provider Manual, as to why there are no other providers available to provide companion services.

a. For CD companion services, the case manager shall determine and document why no other providers are available.

b. Family members who are approved to be reimbursed by DMAS to provide companion services shall meet all of the companion qualifications.

c. 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 MR/ID field, or be a licensed practical nurse (LPN) or a registered nurse (RN) with at least one year of experience working in the MR/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 waiver individual. 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 waiver individual 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 waiver individual 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:

(1) The services facilitator's dated notes documenting any contacts with the waiver individual and the individual's family/caregiver, as appropriate, and visits to the individual's home;

(2) Documentation of training provided to the companion by the individual or EOR, as appropriate;

(3) Documentation of all employee management training provided to the waiver individual and the individual's family/caregiver, as appropriate, including the individual's and the individual's family/caregiver's, as appropriate, receipt of training on their responsibility for the accuracy of the companion's timesheets; and

(4) All documents signed by the waiver individual and the EOR, as appropriate, that acknowledge their responsibilities and legal liabilities as the companion's or companions' employer, as appropriate.

F. Crisis stabilization services. In addition to 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 MR/ID who are experiencing serious psychiatric or behavioral problems. The QMRP shall have: (i) at least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities; (ii) at least either a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology, or a bachelor's degree in another field in addition to an advanced degree in a human services field; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

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 waiver individual's record. The provider shall maintain a record regarding each waiver individual 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

c. 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 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.

2. In addition to licensing requirements, day support staff shall also have training in the characteristics of MR/ID and the appropriate interventions, skill building strategies, and support methods for individuals with MR/ID 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 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 waiver individual 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 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 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 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 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/MR, 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 waiver individuals 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.

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 waiver 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 waiver individual's and the family/caregiver's, and EOR's, as appropriate, request;

e. Understand and agree to comply with the DMAS' MR/ID Waiver requirements; 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/MR, 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 waiver individuals who are minors or the individuals' spouses.

a. Payment shall not be made for services furnished by other family members living under the same roof as the waiver individual receiving services unless there is objective written documentation as to why there are no other providers available to render the services required by the waiver individual. The case manager shall make and document this determination.

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 waiver individuals, 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 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 prior authorization to provide services to the waiver individual must contact the case manager to determine if additional, or modified, prior 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.

c. During temporary, short-term lapses in coverage that are not expected to exceed approximately two weeks in duration, the following procedures must apply:

(1) The prior 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 authorization; and

(3) The prior 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 waiver individual 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 waiver individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The assistant's and waiver 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 waiver individuals 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 waiver individual, 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.

14. For the consumer-directed model, the services facilitator's record shall contain, at a minimum:

a. Documentation of all employee management training provided to the waiver individual and the EOR, as appropriate, including the waiver individual's and the individual's family/caregiver, and EOR, as appropriate, receipt of training on their legal responsibilities for the accuracy and timeliness of the assistant's timesheets;

b. All documents signed by the waiver individual and the EOR, as appropriate, which acknowledge the responsibilities as the employer.

J. Personal Emergency Response Systems. In addition to meeting 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 waiver 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 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, 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. 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 waiver individual.

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 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. This excludes test signals or activations made in error.

K. Prevocational services. In addition to meeting 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 MR/ID and the appropriate interventions, skill building strategies, and support methods for individuals with MR/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. 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. Documentation indicating whether the services were center-based or noncenter-based shall be included on the Plan for Supports.

5. In instances where prevocational staff may be required to ride with the waiver individual 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. 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 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.

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 training in the characteristics of MR/ID and appropriate interventions, skill building strategies, and support methods for individuals who have diagnoses of MR/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 waiver 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 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 are 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/MR, 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 waiver individuals 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 waiver 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 period. The supervisor or services facilitator, as appropriate, shall review the use of respite services either every six months or upon the use of 100 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 attendant;

(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 waiver individual.

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/MR, or nursing facility.

b. Assistants shall have a satisfactory work record, as evidenced by one reference from prior job experiences including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children.

10. Additional requirements for respite assistants for the CD option. The assistant shall:

a. Be willing to attend training at the waiver individual's and the individual family/caregiver's, as appropriate, request;

b. Understand and agree to comply with the DMAS' MR/ID Waiver requirements; and

c. Receive an annual tuberculosis screening.

11. Assistants to be paid by DMAS shall not be the parents of waiver individuals who are minors or the individuals' spouses. Payment shall not be made for services furnished by other family members living under the same roof as the waiver individual who is receiving services unless there is objective written documentation as to why there are no other providers available to render the services required by the waiver individual. The case manager shall make and document this determination. 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 waiver individuals, 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 prior authorization to provide services to the waiver individual must contact the case manager to determine if additional, or modified, prior 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.

c. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures shall apply:

(1) The prior 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 authorization; and

(3) The prior 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 waiver individual 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 waiver individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The assistant's and waiver 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.

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 meet the combination of work experience and relevant education that indicate the possession of the specific knowledge, skills, and abilities as set out in DMAS' guidance documents. The services facilitator shall maintain a record of each individual containing elements as described in the agency guidance documents.

3. For the consumer-directed model, the services facilitator's record shall contain:

a. Documentation of all employee management training provided to the waiver individual and the EOR, as appropriate, including the waiver 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 waiver individual or the EOR, as appropriate, which acknowledge their legal responsibilities as the employer.

O. Skilled nursing services. In addition to meeting 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 waiver individuals who are minors or the waiver individual's spouse nor shall such persons be the employees of companies that render skilled nursing care to the waiver individual. 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 waiver individual 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 waiver individual to such facilities.

5. Skilled nursing services may be ordered but shall not be provided simultaneously with respite care or personal care 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 waiver 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 waiver individual 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 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 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 waiver individual 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 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 family/caregivers to better support the waiver individual 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, the Plan for Supports shall be reviewed by the provider with the individual, and family/caregiver as appropriate, and the case manager, and this written annual review shall be submitted to the case manager, at least annually, or more often as needed. All changes to the Plan for Supports shall be reviewed with 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 12VAC30-120-2010.

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. A waiver individual dies.

c. A waiver individual is discharged from all MR/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 waiver individual and the individual's family/caregiver, as appropriate, of a different community services board/behavioral health authority that provides case management services.

2. Documentation requirements.

a. 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:

(1) The initial comprehensive assessment, subsequent updated assessments, and all Individual Support Plans completed for the individual;

(2) All Plans for Support from every provider rendering waiver services to the individual;

(3) All supporting documentation related to any change in the Individual Support Plans;

(4) 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;

(5) An ongoing log that documents all contacts made by the case manager related to the individual and the individual's family/caregiver, as appropriate; and

(6) When a service provider 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.

b. 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.

c. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides MR/ID Waiver services for the individual.

d. 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 has been initiated by either DBHDS or DMAS.

12VAC30-120-1070. Payment for services.

A. All residential support, day support, supported employment, personal assistance (both agency-directed and consumer directed), respite (both agency-directed and consumer-directed), skilled nursing, therapeutic consultation, crisis stabilization, prevocational, PERS, companion (both agency-directed and consumer directed), consumer-directed services facilitation, 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. All AT and EM covered procedure codes provided in the MR/ID waiver shall be reimbursed as a service limit of one. Effective July 1, 2011, the maximum Medicaid funded expenditure per individual for all AT/EM covered procedure codes (combined total of AT/EM items and labor related to these items) shall be $3,000 per calendar year. No additional mark-ups, such as in the durable medical equipment rules, shall be permitted. Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to the $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. For subsequent calendar years, the limit shall be $3,000 throughout the period.

C. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC 12131 through 42 USC 12165), the Rehabilitation Act of 1973, or the Virginians with Disabilities Act.

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.

12VAC30-120-1080. Utilization review; level of care reviews.

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 and DMAS' guidance documents.

B. Quality management reviews (QMR) shall be performed at least annually by DMAS Division of Long Term Care Services. 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. Waiver individuals who no longer meet the MR/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.

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 waiver applicants 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 shall be based on statewide criteria as specified in DBHDS guidance documents.

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 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 MR/ID;

c. There is a clear risk for the applicant with the MR/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 MR/ID;

e. The applicant with MR/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 MR/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.

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.

12VAC30-120-1090. Appeals.

A. Providers shall have the right to appeal actions taken by DMAS. 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. 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.

NOTICE: The forms used in administering the above regulation are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS (12VAC30-120)

Virginia Uniform Assessment Instrument (UAI) (1994).

Consent to Exchange Information, DMAS-20 (rev. 4/03).

Provider Aide/LPN Record Personal/Respite Care, DMAS-90 (rev. 12/02).

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 Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum (eff. 8/00).

Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 10/06).

Screening Team Plan of Care for Medicaid-Funded Long Term Care, DMAS-97 (rev. 12/02).

Provider Agency Plan of Care, DMAS-97A (rev. 9/02).

Consumer Directed Services Plan of Care, DMAS-97B (rev. 1/98).

Community-Based Care Recipient Assessment Report, DMAS-99 (rev. 4/03).

Consumer-Directed Personal Attendant Services Recipient Assessment Report, DMAS-99B (rev. 8/03).

MI/MR Level I Supplement for EDCD Waiver Applicants, DMAS-101A (rev. 10/04).

Assessment of Active Treatment Needs for Individuals with MI, MR, or RC Who Request Services under the Elder or Disabled with Consumer-Direction Waivers, DMAS-101B (rev. 10/04).

AIDS Waiver Evaluation Form for Enteral Nutrition, DMAS-116 (6/03).

Medicaid Long Term Care Communication Form, DMAS-225 (3/09).

Technology Assisted Waiver/EPSDT 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).

VA.R. Doc. No. R10-2056; Filed September 7, 2011, 1:05 p.m.

TITLE 21. SECURITIES AND RETAIL FRANCHISING

STATE CORPORATION COMMISSION

Final Regulation

REGISTRAR'S NOTICE: The State Corporation Commission is exempt from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

Titles of Regulations: **21VAC5-10. General Administration - Securities Act (amending 21VAC5-10-40).**

21VAC5-80. Investment Advisors (amending 21VAC5-80-210; adding 21VAC5-80-215).

Statutory Authority: §§ 12.1-13 and 13.1-523 of the Code of Virginia.

Effective Date: September 9, 2011.

Agency Contact: Al Hughes, Principal Auditor, State Corporation Commission, Tyler Building, 9th Floor, P.O. Box 1197, Richmond, VA 23218, telephone (804) 371-9415, FAX (804) 371-9911, or email al.hughes@scc.virginia.gov.

Summary:

An amendment to 21VAC5-10-40 replaces the word "chapter" with the word "title."

Subdivision A 7 of 21VAC5-80-210 is repealed and a new section, 21VAC5-80-215, is added that grants certain investment advisors and investment advisor representatives an exemption from the registration provisions of the Virginia Securities Act provided the investment advisor was exempt from registration pursuant to § 203(b)(3) of the Investment Advisors Act of 1940 (40 Act) prior to July 21, 2011, and the investment advisor is subject to SEC Rule 203-1(e) granting an extension to those investment advisors formerly exempt from registration under § 203 (b)(3) of the 40 Act until March 30, 2012, who would otherwise have been required to register with the SEC by July 21, 2011.

AT RICHMOND, SEPTEMBER 7, 2011

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. SEC-2011-00034

Ex Parte: In the matter of Adopting a Revision
to the Rules Governing the Virginia Securities Act

ORDER ADOPTING AMENDED RULES

By order entered on July 25, 2011, all interested persons were ordered to take notice that the State Corporation Commission ("Commission") would consider the adoption of a revision to Chapters 10 and 80 of Title 21 of the Virginia Administrative Code ("Regulations") entitled "Rules and Forms Governing Virginia Securities Act." On August 8, 2011, the Division of Securities and Retail Franchising ("Division") mailed the Order to Take Notice of the proposed Regulations to all interested parties pursuant to the Virginia Securities Act, § 13.1-501 et seq. of the Code of Virginia. The Order to Take Notice described the proposed amendments and afforded interested parties an opportunity to file comments and request a hearing by August 29, 2011, with the Clerk of the Commission.

No comments were filed nor were any requests for hearing made in this matter.

The Commission, upon consideration of the proposed amendments to the Regulations the recommendations of the Division, and the record in this case, finds that the proposed amendments to the Regulations should be adopted.

Accordingly, IT IS ORDERED THAT:

(1) The proposed Regulations are attached hereto, made a part hereof, and are hereby ADOPTED effective September 9, 2011.

(2) This matter is dismissed from the Commission's docket, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY of this Order shall be sent to each of the following by the Division to: the Commission's Division of Information Resources; the Commission's Office of General Counsel; and such other persons as the Division deems appropriate.

21VAC5-10-40. Definitions.

As used in this ~~chapter~~ title, the following regulations and forms pertaining to securities, instructions and orders of the commission, the following meanings shall apply:

"Act" means the Securities Act contained in Chapter 5 (§ 13.1-501 et seq.) of Title 13.1 of the Code of Virginia.

"Applicant" means a person on whose behalf an application for registration or a registration statement is filed.

"Application" means all information required by the forms prescribed by the commission as well as any additional information required by the commission and any required fees.

"Bank Holding Company Act of 1956" (12 USC § 1841 et seq.) means the federal statute of that name as now or hereafter amended.

"Boiler room tactics" mean operations or high pressure tactics utilized in connection with the promotion of speculative offerings by means of an intensive telephone campaign or unsolicited calls to persons not known by or having an account with the salesmen or broker-dealer represented by him, whereby the prospective purchaser is encouraged to make a hasty decision to invest, irrespective of his investment needs and objectives.

"Breakpoint" means the dollar level of investment necessary to qualify a purchaser for a discounted sales charge on a quantity purchase of open-end management company shares.

"Commission" means State Corporation Commission.

"Federal covered advisor" means any person who is registered or required to be registered under § 203 of the Investment Advisers Act of 1940 as an "investment adviser."

"Investment Advisers Act of 1940" (15 USC § 80b-1 et seq.) means the federal statute of that name as now or hereafter amended.

Notwithstanding the definition in § 13.1-501 of the Act, "investment advisor representative" as applied to a federal covered advisor only includes an individual who has a "place of business" (as that term is defined in rules or regulations promulgated by the SEC) in this Commonwealth and who either:

1. Is an "investment advisor representative" as that term is defined in rules or regulations promulgated by the SEC; or

2. a. Is not a "supervised person" as that term is defined in the Investment Advisers Act of 1940; and

b. Solicits, offers or negotiates for the sale of or sells investment advisory services on behalf of a federal covered advisor.

"Investment Company Act of 1940" (15 USC § 80a-1 et seq.) means the federal statute of that name as now or hereafter amended.

"NASAA" means the North American Securities Administrators Association, Inc.

"NASD" means the National Association of Securities Dealers, Inc., or its successor, the Financial Industry Regulatory Authority, Inc. (FINRA).

"Notice" or "notice filing" means, with respect to a federal covered advisor or federal covered security, all information

required by the regulations and forms prescribed by the commission and any required fee.

"Registrant" means an applicant for whom a registration or registration statement has been granted or declared effective by the commission.

"SEC" means the United States Securities and Exchange Commission.

"Securities Act of 1933" (15 USC § 77a et seq.) means the federal statute of that name as now or hereafter amended.

"Securities Exchange Act of 1934" (15 USC § 78a et seq.) means the federal statute of that name as now or hereafter amended.

"Solicitation" means an offer to one or more persons by any of the following means or as a result of contact initiated through any of these means:

1. Television, radio, or any broadcast medium;

2. Newspaper, magazine, periodical, or any other publication of general circulation;

3. Poster, billboard, Internet posting, or other communication posted for the general public;

4. Brochure, flier, handbill, or similar communication, unless the offeror has a substantial preexisting business relationship or close family or personal relationship with each of the offerees;

5. Seminar or group meeting, unless the offeror has a substantial preexisting business relationship or close family or personal relationship with each of the offerees; or

6. Telephone, facsimile, mail, delivery service, or electronic communication, unless the offeror has a substantial preexisting business relationship or close family or personal relationship with each of the offerees.

Part IV
Exclusions

21VAC5-80-210. Exclusions from definition of "investment advisor" and "federal covered advisor."

A. The terms "investment advisor" and "federal covered advisor" do not include any person engaged in the investment advisory business whose only client is one (or more) of the following:

1. An investment company as defined in the Investment Company Act of 1940.

2. An insurance company licensed to transact insurance business in this Commonwealth.

3. A bank, a bank holding company as defined in the Bank Holding Company Act of 1956, a trust subsidiary organized under Article 3.1 (§ 6.1-32.1 et seq.) of Chapter 2 of Title 6.1 of the Code of Virginia, a savings institution, a credit union, or a trust company if the entity is either (i) authorized or licensed to transact such business in this Commonwealth or (ii) organized under the laws of the United States.

4. A broker-dealer so registered under the Act and under the Securities Exchange Act of 1934.

5. An employee benefit plan with assets of not less than $5,000,000.

6. A governmental agency or instrumentality.

~~7. A corporation, general partnership, limited partnership, limited liability company, trust or other legal organization that (i) has assets of not less than $5,000,000 and (ii) receives investment advice based on its investment objectives rather than the individual investment objectives of its shareholders, partners, limited partners, members or beneficiaries, provided the investment advisor or federal covered advisor is exempt from registration pursuant to § 203(b)(3) of the Investment Advisors Act of 1940 or by any rule or regulation promulgated by the SEC under that section. If the entity's assets fall below $5,000,000 for a period not to exceed 90 days, the investment advisor shall file an application to register with the division within 30 days.~~

B. Any investment advisor or federal covered advisor who (i) does not have a place of business located within this Commonwealth and (ii) during the preceding 12-month period has had fewer than six clients who are residents of this Commonwealth other than those listed in subsection A of this section is excluded from the registration and notice filing requirements of the Act.

C. The term "investment advisor" does not include any certified public accountant who holds a valid CPA certificate as defined by § 54.1-2000 of Title 54.1 of the Code of Virginia and who during the ordinary course of business:

1. Issues publications, writings, reports, or testimony in a court of law or in an arbitration as to the value of privately held securities in a transaction involving the purchase, sale or valuation of a business;

2. Issues publications, writings, reports or testimony in a court of law or in an arbitration as to the advisability of investing in, purchasing, or selling privately held securities in a transaction involving the purchase, sale or valuation of a business; or

3. Advises clients about the disposition or value of assets, of which ownership is evidenced by privately held securities and such assets are the subject of (i) bankruptcy, (ii) estate or gift tax planning or settlement, (iii) divorce, (iv) sale of a business, whether whole or in part, (v) employee stock option plan, or (vi) an insurance settlement.

21VAC5-80-215. Exemption for certain private advisors.

Registration under the Act shall not be required of any investment advisor or its investment advisor representative whose only client is or clients are a corporation, general partnership, limited partnership, limited liability company, trust, or other legal organization that:

1. Has assets of not less than $5,000,000 and

2. Receives investment advice based on its investment objectives rather than the individual investment objectives of its shareholders, partners, limited partners, members, or beneficiaries, provided the investment advisor was exempt from registration pursuant to § 203(b)(3) of the Investment Advisors Act of 1940 immediately prior to July 21, 2011, and the investment advisor is subject to SEC Rule 203-1(e) granting an extension to investment advisors formerly exempt from registration under § 203(b)(3) of the Investment Advisers Act of 1940 until March 30, 2012, who would otherwise have been required to register with the SEC by July 21, 2011.

VA.R. Doc. No. R11-2924; Filed September 7, 2011, 12:44 p.m.

EXECUTIVE ORDER NUMBER 38 (2011)

Declaration of a State of Emergency for the Commonwealth of Virginia Due to a 5.8 Magnitude Earthquake and Aftershocks Affecting Localities throughout Virginia

Importance of the Issue

On August 23, 2011, I verbally declared a state of emergency to exist for the Commonwealth of Virginia based on a 5.8 magnitude earthquake occurring on August 23, 2011 and a series of aftershocks that affected localities throughout the Commonwealth.

The health and general welfare of the citizens require that state action be taken to help alleviate the conditions caused by this situation. The effects of this earthquake constitute a disaster wherein human life and public and private property are imperiled, as described in § 44-146.16 of the Code of Virginia.

Therefore, by virtue of the authority vested in me by § 44-146.17 of the Code of Virginia, as Governor and as Director of Emergency Management, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by § 44-75.1 of the Code of Virginia, as Governor and Commander-in-Chief of the armed forces of the Commonwealth, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby confirm, ratify, and memorialize in writing my verbal orders issued on August 23, 2011, whereby I proclaimed that a state of emergency exists and directed that appropriate assistance be rendered by agencies of both state and local governments to alleviate any conditions resulting from significant events, and to implement recovery and mitigation operations and activities so as to return impacted areas to pre-event conditions in so far as possible.

In order to marshal all public resources and appropriate preparedness, response, and recovery measures to meet this threat and recover from its effects, and in accordance with my authority contained in § 44-146.17 of the Code of Virginia, I hereby order the following protective and restoration measures:

A. Implementation by agencies of the state and local governments of the Commonwealth of Virginia Emergency Operations Plan (COVEOP), as amended, along with other appropriate state agency plans.

B. Activation of the Virginia Emergency Operations Center (VEOC) and the Virginia Emergency Response Team (VERT) to coordinate the provision of assistance to local governments. I am directing that the VEOC and VERT coordinate state actions in support of affected localities, other mission assignments to agencies designated in the COVEOP and to others that may be identified by the State Coordinator of Emergency Management, in consultation with the Secretary of Public Safety, which are needed to provide for the preservation of life, protection of property, and implementation of recovery activities.

C. The authorization to assume control over the Commonwealth's state-operated telecommunications systems, as required by the State Coordinator of Emergency Management, in coordination with the Virginia Information Technology Agency, and with the consultation of the Secretary of Public Safety, making all systems assets available for use in providing adequate communications, intelligence and warning capabilities for the event, pursuant to § 44-146.18 of the Code of Virginia.

D. The activation, implementation, and coordination of appropriate mutual aid agreements and compacts, including the Emergency Management Assistance Compact (EMAC), and the authorization of the State Coordinator of Emergency Management to enter into any other supplemental agreements, pursuant to § 44-146.17(5) and § 44-146.28:1 of the Code of Virginia, to provide for the evacuation and reception of injured and other persons and the exchange of medical, fire, police, public utility, reconnaissance, welfare, transportation and communications personnel, and equipment and supplies. The State Coordinator of Emergency Management is hereby designated as Virginia's authorized representative within the meaning of the Emergency Management Assistance Compact, § 44-146.28:1 of the Code of Virginia.

E. The authorization of the Departments of State Police, Transportation, and Motor Vehicles to grant temporary overweight, over width, registration, or license exemptions to all carriers transporting essential emergency relief supplies or providing restoration of utilities (electricity, gas, phone, water, wastewater, and cable) in and through any area of the Commonwealth in order to support the disaster response and recovery, regardless of their point of origin or destination.

All over width loads, up to a maximum of 12 feet, must follow Virginia Department of Motor Vehicles (DMV) hauling permit and safety guidelines.

In addition to described overweight/over width transportation privileges, carriers are also exempt from registration with the Department of Motor Vehicles. This includes vehicles in route and returning to their home base. The above-cited agencies shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

Authorization of the State Coordinator of Emergency Management to grant limited exemption of hours worked for carriers when transporting passengers, property, equipment, food, fuel, construction materials, and other critical supplies to or from any portion of the Commonwealth for purpose of providing relief or assistance as a result of this disaster,

pursuant to § 52-8.4 of the Code of Virginia and Title 49 Code of Federal Regulations, Section 390.23 and Section 395.3.

The foregoing overweight/over width transportation privileges as well as the regulatory exemption provided by § 52-8.4(A) of the Code of Virginia, and implemented in § 19 VAC 30-20-40(B) of the "Motor Carrier Safety Regulations," shall remain in effect for 30 days from the onset of the disaster or until emergency relief is no longer necessary, as determined by the Secretary of Public Safety in consultation with the Secretary of Transportation, whichever is earlier.

F. The discontinuance of provisions authorized in paragraph E above may be implemented and disseminated by publication of administrative notice to all affected and interested parties by the authority I hereby delegate to the Secretary of Public Safety, after consultation with other affected Cabinet-level Secretaries.

G. The authorization of a maximum of $100,000 for matching funds for the Individuals and Household Program, authorized by The Stafford Act (when presidentially authorized), to be paid from state funds.

H. The implementation by public agencies under my supervision and control of their emergency assignments as directed in the COVEOP without regard to normal procedures pertaining to performance of public work, entering into contracts, incurring of obligations or other logistical and support measures of the Emergency Services and Disaster Laws, as provided in § 44-146.28(b) of the Code of Virginia. Section 44-146.24 of the Code of Virginia also applies to the disaster activities of state agencies.

I. Designation of members and personnel of volunteer, auxiliary, and reserve groups including search and rescue (SAR), Virginia Associations of Volunteer Rescue Squads, Civil Air Patrol, member organizations of the Voluntary Organizations Active in Disaster, Radio Amateur Civil Emergency Services, volunteer fire fighters, Citizen Corps Programs such as Medical Reserve Corps, Citizen Emergency Response Teams, and others identified and tasked by the State Coordinator of Emergency Management for specific disaster related mission assignments as representatives of the Commonwealth engaged in emergency services activities within the meaning of the immunity provisions of § 44-146.23(A) and (F) of the Code of Virginia, in the performance of their specific disaster-related mission assignments.

J. The authorization of appropriate oversight boards, commissions, and agencies to ease building code restrictions and to permit emergency demolition, hazardous waste disposal, debris removal, emergency landfill siting, and operations and other activities necessary to address immediate health and safety needs without regard to time-consuming procedures or formalities and without regard to application or permit fees or royalties.

K. The activation of the statutory provisions in § 59.1-525 et seq. of the Code of Virginia related to price gouging. Price gouging at any time is unacceptable. Price gouging is even more reprehensible after a natural disaster. I have directed all applicable executive branch agencies to take immediate action to address any verified reports of price gouging of necessary goods or services. I make the same request of the Office of the Attorney General and appropriate local officials.

Upon my approval, the costs incurred by state agencies and other agents in performing mission assignments through the VEOC of the Commonwealth as defined herein and in § 44-146.28 of the Code of Virginia shall be paid from state funds and/or federal funds. In addition, up to $100,000 shall be made available for state response and recovery operations and incident documentation, with the Department of Planning and Budget overseeing the release of these funds.

Effective Date of this Executive Order

This Executive Order shall be effective retroactively to August 23, 2011, and shall remain in full force and effect until June 30, 2012, unless sooner amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 31st day of August, 2011.

/s/ Robert F. McDonnell
Governor

EXECUTIVE ORDER NUMBER 39 (2011)

Multidisciplinary Taskforce on Economic Competitiveness and Versatility

Importance of the Issue

The Commonwealth of Virginia continues to be recognized by many as the most business-friendly, entrepreneurial, and dynamic economy in the nation. Maintaining this status requires the constant monitoring of market forces; agile adaptation to new information; vigilance against new programs and trends that would extend government beyond core services; and swift response even to risk factors outside of our immediate legislative or budgetary control. Modern Virginians are the beneficiaries of over a century of sound fiscal management and we will pass that good inheritance to future generations. Virginia has held its treasured AAA bond rating from each of the three rating agencies longer than any other state in the Union.

Today we are faced with the stark reality that our federal government has not followed Virginia's example of thrift, moderation, and restraint. For the first time, the credit rating of the world's greatest economy has been downgraded by at least one rating agency. While we may doubt the wisdom and

timing of that downgrade, there is no doubt that the size, scope, debt, and spending of the federal government has grown at an unconscionable and unsustainable pace. Because it has not lived within its means for decades, the federal government is now forced to take bold steps to change course. Virginia welcomes those necessary and inevitable federal budget reforms and will, as it has in every prior change of course in federal spending, do its part in preparing for the impact and come out stronger than before. That includes a continuing effort to diversify our state's economy into multiple high and long-term growth sectors.

The connection between Virginia and the federal government is well-known both politically and economically, but difficult to accurately quantify. Less than five percent of Virginia workers are federal employees; moreover, 92 percent of all the jobs created since February 2010 are in the private sector. Still "[t]he people of Virginia are acutely aware of the integral role military and national security facilities play in the economic vitality of the Commonwealth. The estimated $56 billion the Department of Defense alone is projected to spend in the Commonwealth in 2010 translates to business for Virginia and high-quality jobs for our citizens." (Governor's Exec. Order No. 22 (2010))

In 2009, Virginia ranked first among the states in total per capita federal expenditures. The Commonwealth also ranked first in per capita spending for procurement, second in defense spending, fourth in salaries and wages, and fifth in retirement and disability payments. Conversely, Virginia ranked 39th in per capita federal spending for direct payments and next to last in per capita federal grant spending. Because of this wide diversity in the measurement of federal spending in Virginia, and because we do not know what form anticipated federal reforms will take, we have to take steps now to prepare for the potential impact on our revenue from personal withholdings and corporate income taxes, as well as the secondary impact on sales and other taxes. In addition, while we have a relatively low unemployment rate around 6 percent, there are far too many Virginians out of work. We must continue to focus our efforts on the expansion, retention, and recruitment of jobs.

Virginia will be vigilant in protecting the military and national security assets located in the Commonwealth as authorized in Executive Order 22, but must continuously seek new opportunities for growth. To that end, the Lieutenant Governor, in his capacity as Chief Job Creation Officer, will be charged with leading a multidisciplinary taskforce to identify strategies to further strengthen the Commonwealth's economic diversity and competitiveness in light of future federal action.

To accomplish this, in accordance with the authority vested in me by Article V of the Constitution of Virginia and by Section 2.2-134 of the Code of Virginia, I hereby create the Multidisciplinary Taskforce on Economic Competitiveness and Versatility.

<u>The Multidisciplinary Taskforce on Economic Competitiveness and Versatility</u>

The Taskforce will consist of the Lieutenant Governor, the Secretary of Finance, the Secretary of Commerce and Trade, the Secretary of Technology, the Secretary of Veterans Affairs and Homeland Security, the Senior Economic Advisor, the Director of the Office of Intergovernmental Affairs, the President and CEO of the Virginia Economic Development Partnership, as well as others appointed by the Governor who will serve at his pleasure and at his discretion.

The Multidisciplinary Taskforce's responsibilities shall include the following:

1. Analyze and report to the Governor the state of Virginia's workforce and its degree of versatility to respond to future contraction in federal spending, both in terms of individual regions and economic sectors.

2. Identify appropriate opportunities for further diversifying Virginia's economy to help reduce private sector reliance on federal spending and provide alternative employment for potentially displaced federal workers.

3. Receive from the private sector, economic development allies, institutions of higher education, legislators, elected officials, and other interested parties ideas for promoting Virginia's economic versatility and analyzing those ideas for further action by the Governor.

4. Manage the communication among the Commonwealth of Virginia, the Joint Select Committee on Deficit Reduction as established in the Budget Control Act of 2011 (Public Law No: 112-25), and the Virginia congressional delegation relative to any budget reform proposals and their impacts on the Commonwealth.

5. Quantify and report to the Governor the impact to the Commonwealth, its subdivisions, and private industry of any such proposals to address the federal deficit.

6. Identify the regions, localities, and economic sectors most readily affected by federal contraction or budget reform proposals.

7. Support and foster collaboration among local and regional entities in identifying appropriate strategies for adaptation to changes in federal spending and policies.

8. Determine the best and most efficient manner to foster and promote business, technology, transportation, education, economic development and other efforts to support, attract and retain a broad array of new private sector businesses to the Commonwealth.

9. Determine, in conjunction with the Commission on National Security Facilities, the best and most efficient

manner to foster and promote business, technology, transportation, education, economic development and other efforts to support and retain existing military and non-military national security facilities in the Commonwealth.

10. Inform the Governor on a regular basis on all pertinent findings and recommendations.

Multidisciplinary Taskforce Staffing and Funding

Necessary staff support for the Multidisciplinary Taskforce's work during its existence shall be furnished by the Office of the Governor and the Office of the Secretary of Commerce and Trade, and such other agencies and offices as designated by the Governor. An estimated 150 hours of staff time will be required to support the work of the Interagency Taskforce. No public funds will be expended in support of this Taskforce.

The Taskforce shall report quarterly, beginning on October 1, 2011, to the Governor and shall issue such other reports and recommendations as necessary or as requested by the Governor.

Effective Date of the Executive Order

This Executive Order shall be effective upon its signing and pursuant to Section 2.2-135 of the Code of Virginia shall remain in force and effect until August 31, 2012, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 1st day of September 2011.

/s/ Robert F. McDonnell
Governor

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Agricultural Stewardship Act 2010 Annual Report

The Commissioner of Agriculture and Consumer Services announces the availability of the annual report of the Agricultural Stewardship Act entitled "Virginia Agricultural Stewardship Act Annual Report, April 1, 2010 - March 31, 2011: A Positive Approach." Copies of this report can be obtained by contacting Joyce Knight at (804) 786-3538 or email at joyce.knight@vdacs.virginia.gov. The report can also be obtained from the Department of Agriculture and Consumer Services' website at http://www.vdacs.virginia.gov/stewardship/index.shtml. A written request may be sent to Virginia Department of Agriculture and Consumer Services, Office of Policy, Planning and Research, P.O. Box 1163, 102 Governor Street, Suite 219, Richmond, VA 23218. Copies of the report are available without charge. Questions regarding the report may be directed to (804) 786-3538.

STATE AIR POLLUTION CONTROL BOARD

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality (DEQ) is conducting a periodic review of portions of the Regulations for the Control and Abatement of Air Pollution; specifically, certain regulations of 9VAC5-40, Existing Stationary Sources. The purpose of the regulations is to control emissions from specific types of existing stationary sources to protect human health and the environment. The specific regulations being reviewed are as follows: Part I- Special Provisions; Part II- Emission Standards Article 2, Odor; Article 4, General Process Operations; Article 8, Fuel Burning Equipment; Article 15, Coal Preparation Plants; Article 37, Petroleum Liquid Storage and Transfer Operations; Article 43, Municipal Solid Waste Landfills; Article 46, Small Municipal Waste Combustors; Article 47, Solvent Cleaning; Article 48, Mobile Equipment Repair and Refinishing; Article 52, Case-by-case BART Determinations; Article 53, Lithographic Printing Processes; and Article 54, Large Municipal Waste Combustors. The regulations may be viewed on the DEQ air regulation web page: http://www.deq.state.va.us/air/regulations/airregs.html.

The review of this regulation will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia.

The purpose of this review is to determine whether these regulations should be terminated, amended, or retained in their current form. Public comment is sought on the review of any issue relating to these regulations, including whether (i) the regulations are effective in achieving their goals; (ii) the regulations are necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulations; (iv) the regulation minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (v) the regulations are clearly written and easily understandable.

The comment period begins September 26, 2011, and ends on October 17, 2011.

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 Karen G. Sabasteanski, Policy Analyst, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4426, FAX (804) 698-4510, or email karen.sabasteanski@deq.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 the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality (DEQ) is conducting a periodic review of portions of the Regulations for the Control and Abatement of Air Pollution; specifically, certain regulations of 9VAC5-50, New and Modified Stationary Sources. The purpose of the regulations is to control emissions from specific types of new and modified existing stationary sources to protect human health and the environment. The specific regulations being reviewed are as follows: Part I- Special Provisions; Part II- Emission Standards: Article 2, Odorous emissions; Article 4, Stationary Sources; and Article 6, Medical Waste Incinerators. The regulations may be viewed on the DEQ air regulation web page: http://www.deq.state.va.us/air/regulations/airregs.html.

The review of these regulations will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia.

The purpose of this review is to determine whether these regulations should be terminated, amended, or retained in their current form. Public comment is sought on the review of any issue relating to these regulations, including whether (i) the regulations are effective in achieving their goals; (ii) the regulations are necessary for the protection of public health, safety, and welfare or for the economical performance of

important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulations; (iv) the regulation minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (v) the regulations are clearly written and easily understandable.

The comment period begins September 26, 2011, and ends on October 17, 2011.

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 Karen G. Sabasteanski, Policy Analyst, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4426, FAX (804) 698-4510, or email karen.sabasteanski@deq.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 the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality (DEQ) is conducting a periodic review of portions of the Regulations for the Control and Abatement of Air Pollution; specifically, 9VAC5-70, Air Pollution Episode Prevention. The purpose of the regulation is to prevent air pollution to protect human health and the environment. The regulation may be viewed on the DEQ air regulation web page: http://www.deq.state.va.us/air/regulations/airregs.html.

The review of this regulation will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia.

The purpose of this review is 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 (i) the regulation is effective in achieving its goals; (ii) the regulation is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulation; (iv) the regulation minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (v) the regulation is clearly written and easily understandable.

The comment period begins September 26, 2011, and ends on October 17, 2011.

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 Karen G. Sabasteanski, Policy Analyst, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4426, FAX (804) 698-4510, or email karen.sabasteanski@deq.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 the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality (DEQ) is conducting a periodic review of portions of a regulation of the State Air Pollution Control Board; specifically, 9VAC5-221, Variance for Rocket Motor Test Operations at Atlantic Research Corporation Gainesville Facility. The purpose of the regulation is to control emissions from the Rocket Motor Test Operations at Atlantic Research Corporation's Gainesville Facility to protect human health and the environment. The regulation may be viewed on the DEQ air regulation web page: http://www.deq.state.va.us/air/regulations/airregs.html.

The review of this regulation will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia.

The purpose of this review is 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 (i) the regulation is effective in achieving its goals; (ii) the regulation is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulation; (iv) the regulation minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (v) the regulation is clearly written and easily understandable.

The comment period begins September 26, 2011, and ends on October 17, 2011.

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 Karen G. Sabasteanski, Policy Analyst, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4426, FAX (804) 698-4510, email karen.sabasteanski@deq.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 the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality (DEQ) is conducting a periodic review of a regulation of the State Air Pollution Control Board; specifically, 9VAC5-510, General Permit for Nonmetallic Mineral Mining. The purpose of the regulation is to control emissions from nonmetallic mineral mining sources to protect human health and the environment. The regulation may be viewed on the DEQ air regulation webpage: http://www.deq.state.va.us/air/regulations/airregs.html.

The review of this regulation will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia.

The purpose of this review is 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 (i) the regulation is effective in achieving its goals; (ii) the regulation is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulation; (iv) the regulation minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (v) the regulation is clearly written and easily understandable.

The comment period begins September 26, 2011, and ends on October 17, 2011.

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 Karen G. Sabasteanski, Policy Analyst, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4426, FAX (804) 698-4510, email karen.sabasteanski@deq.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 the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

VIRGINIA BOARD FOR ASBESTOS, LEAD, MOLD, AND HOME INSPECTORS

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board for Asbestos, Lead, Mold, and Home Inspectors is currently reviewing each of the regulations listed below to determine whether it should be terminated, amended, or retained in their current form. The review of the regulations will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia. Each regulation will be reviewed to determine 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.

18VAC15-11, Public Participation Guidelines

18VAC15-20, Virginia Asbestos Licensing Regulations

18VAC15-30, Virginia Lead-Based Paint Activities Regulations

18VAC15-40, Certified Home Inspector Regulations

18VAC15-60, Mold Inspector and Mold Remediator Licensing Regulation

The comment period begins September 26, 2011, and ends on October 17, 2011.

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 David E. Dick, Executive Director, Board for Asbestos, Lead, Mold, and Home Inspectors, Department of Professional and Occupational Regulation, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (866) 350-5354, or email alhi@dpor.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 the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Total Maximum Daily Load for Bear Garden Creek and North Creek

The Department of Environmental Quality (DEQ) seeks written and oral comments from interested persons on the development of a total maximum daily load (TMDL) for Bear Garden Creek and North Creek. Bear Garden Creek was listed on the 2002 § 303(d) TMDL Priority List and Report as impaired due to violations of the state's water quality standards for total fecal coliform bacteria. Bear Garden Creek is located in Buckingham County, Virginia. The impaired segment of the Bear Garden Creek is 9.2 miles in length, to include the entire headwaters and extends downstream to the mouth of the James River. North Creek was listed on the 2002 § 303(d) TMDL Priority List and Report as impaired due to violations of Virginia's water quality standards for benthics. North Creek is located in Fluvanna County, Virginia. The impaired segment of North Creek is ~6.5 miles, to include the entire headwaters and extends to the mouth of South Creek.

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.

The final public meeting on the development of the Bear Garden Creek and North Creek TMDL will be held on Tuesday, October 4, 2011, 7 p.m. in the Arvonia Firehouse located on Route 675 in Buckingham, Virginia. (From Dillwyn, Route 15 to North 12 miles. Left on Route 715. Left on Route 675. Arvonia firehouse on left (less than 1/4 mile)).

The public comment period for this phase of the TMDL development will end on November 2, 2011. A fact sheet on the development of the Bear Garden Creek and North Creek TMDL is available upon request. Questions or information requests should be addressed to Paula Nash. Written comments should include the name, address, and telephone number of the person submitting the comments and should be sent to Paula B. Nash, Department of Environmental Quality, 7705 Timberlake Road, Lynchburg, VA 24502, telephone (434) 582-6216, FAX (434) 582-5125, or email paula.nash@deq.virginia.gov.

Total Maximum Daily Load Study and Implementation Plan in Hoffler Creek; Cities of Suffolk and Portsmouth

The Virginia Department of Environmental Quality (DEQ) will host a public meeting on a water quality study for Hoffler Creek, located in the Cities of Suffolk and Portsmouth, on Tuesday, September 27, 2011.

The meeting will start at 6:30 p.m. in the Northern Shores Elementary School media room located at 6701 Respass Beach Road, Suffolk, Virginia. The purpose of the meeting is to provide information and discuss the study with interested local community members and local government.

Hoffler Creek (VAT-G15E_HOF01A06) was identified in Virginia's Water Quality Assessment Integrated Report as impaired for not supporting the primary contact use. The impairment is based on water quality monitoring data reports of sufficient exceedances of Virginia's water quality standard for bacteria.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop total maximum daily loads (TMDLs) for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report and subsequent water quality assessment reports.

The meeting will review the final TMDL for the impaired water. A TMDL is the total amount of a pollutant a water body can contain and still meet water quality standards. To restore water quality, pollutant levels have to be reduced to the TMDL amount.

The implementation plan (IP) is developed to provide a clean up plan that will lead to attainment of the water quality standards. Public participation and stakeholder involvement are necessary in order to develop an effective and reasonable IP. This meeting will present the findings of the TMDL study and the necessary steps in the IP development. A Technical Advisory Committee (TAC) and/or work groups will also be formed in order to provide detailed information during the IP process.

The public comment period on materials presented at this meeting will extend from September 28, 2011, to October 27, 2011. For additional information or to submit comments, contact Jennifer Howell, Virginia Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Blvd., Virginia Beach, VA 23462, telephone (757) 518-2111, or email jennifer.howell@deq.virginia.gov. Additional information is also available on the DEQ website at www.deq.virginia.gov/tmdl.

Cleanup Plan for Mill Creek Watershed, Northampton County

The Virginia Department of Environmental Quality (DEQ), Virginia Department of Conservation & Recreation, and the Northampton County Planning Department will host a public meeting on Monday, September 26, 2011, on the development of a cleanup plan for a waterway in Northampton County. Participants will have the opportunity to contribute to the watershed cleanup plan.

The meeting will start at 6:30 p.m. in the conference room of the Northampton County Administrative Offices located at 7247 Young Street, Machipongo, Virginia.

Citizens are invited to discuss the development of an implementation plan (IP) to address water quality impairments in the Mill Creek Watershed. Water quality monitoring indicates that levels of dissolved oxygen, pH, and bacteria in Mill Creek violate Virginia's water quality standards for its designated recreation use. A total maximum daily load (TMDL) study for the dissolved oxygen impairment was approved by EPA in 2009 and is available on DEQ's website at http://www.deq.virginia.gov/tmdl/develop.html.

The IP is developed to provide a clean up plan that will lead to attainment of the water quality standards. Public participation and stakeholder involvement are necessary to develop an effective and reasonable IP. This meeting will present the findings of the TMDL study and the necessary steps in the IP development. A Technical Advisory Committee (TAC) and/or work groups will also be formed in order to provide detailed information during the IP process.

How to comment: The public comment period on the development of the IP will end on October 26, 2011. Oral comments will be accepted and addressed at the public meeting. For additional questions or information or to submit comments, contact Jennifer Howell, TMDL Coordinator, Department of Environmental Quality, 5636 Southern Blvd., Virginia Beach, VA 23262, telephone (757) 518-2111, FAX (757) 518-2009, or email jennifer.howell@deq.virginia.gov. Written comments and inquiries should include the name, address, and telephone number of the person submitting the comments.

Total Maximum Daily Load Studies in the Cities of Virginia Beach and Chesapeake

The Virginia Department of Environmental Quality (DEQ) will host a public meeting on water quality studies for several creeks located in the Cities of Virginia Beach and Chesapeake on Monday, October 3, 2011.

The meeting will start at 4 p.m. at Creeds Ruritan Barn, Virginia Beach Farm Bureau Office located at 1057 Princess Anne Road, Virginia Beach, Virginia. The purpose of the meeting is to provide information and discuss the study with interested local community members and local government.

Redhead Bay at Drum Point, Beggars Bridge Creek, Upper and Lower Hell Point Creek, Muddy Creek, Lower Ashville Bridge Creek, and Middle North Landing River were identified in Virginia's Water Quality Assessment and Integrated Report as impaired for not supporting the primary contact use. The impairment is based on water quality monitoring data reports of sufficient exceedances of Virginia's water quality standard for bacteria.

Pocaty River and Blackwater Creek were identified in Virginia's Water Quality Assessment and Integrated Report as impaired for not supporting the aquatic life use. The impairment is based on water quality monitoring data reports of sufficient violations of Virginia's water quality standard for dissolved oxygen.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia, require DEQ to develop total maximum daily loads (TMDLs) for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report and subsequent water quality assessment reports.

During the study, DEQ will develop 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, pollutant levels have to be reduced to the TMDL amount.

The public comment period on materials presented at this meeting will extend from October 4, 2011, to November 2, 2011. For additional information or to submit comments, contact Jennifer Howell, Virginia Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Blvd., Virginia Beach, VA 23462, telephone (757) 518-2111, or email jennifer.howell@deq.virginia.gov. Additional information is also available on the DEQ website at www.deq.virginia.gov/tmdl.

Proposed State Implementation Plan Revision - Facility in Fluvanna County

Notice of action: The Department of Environmental Quality (DEQ) is announcing an opportunity for public comment on a proposed plan regarding air pollution emitted by a facility in Fluvanna County, Virginia. The Commonwealth intends to submit the plan as a revision to the Commonwealth of Virginia state implementation plan (SIP) in accordance with the requirements of § 110(a) of the federal Clean Air Act. The SIP is the plan developed by the Commonwealth in order to fulfill its responsibilities under the federal Clean Air Act to attain and maintain the ambient air quality standards promulgated by the U.S. Environmental Protection Agency (EPA) under the Act.

Purpose of notice: DEQ is seeking comments on whether a now-obsolete permit that had established emission limits for NO_X for certain affected units in compliance with the provisions of EPA's Phase II NO_X SIP Call Rule should be removed from the SIP.

Public comment period: September 26, 2011, to October 26, 2011.

Public hearing: Department of Environmental Quality, Valley Regional Office, 4411 Early Road, Conference Room, P.O. Box 3000, Harrisonburg, Virginia, at 6 p.m. on October 26, 2011.

Description of proposal: The Transcontinental Gas Pipe Line Corporation (Registration No. 40789) has permanently shut

down four large stationary natural gas-fired, spark ignited, reciprocating IC engines that were permitted in order to comply with the provisions of EPA's Phase II NO_X SIP Call Rule. Because these units are permanently shut down, DEQ is requesting that EPA remove the permit from the SIP. Once EPA has approved this request and DEQ has notified the owner of this approval, the permit repeal will become effective 30 days later. DEQ is seeking comments on the issue of whether the now-obsolete permit should be removed from the SIP.

Federal information: This notice is being given to satisfy the public participation requirements of federal regulations (40 CFR 51.102). The proposal will be submitted as a revision to the Commonwealth of Virginia SIP under § 110(a) of the federal Clean Air Act in accordance with 40 CFR 51.104.

How to comment: DEQ accepts written comments by email, fax, and postal mail. In order to be considered, written comments must include the full name, address, and telephone number of the person commenting and be received by DEQ by the last day of the comment period. Commenters submitting faxes are encouraged to provide the signed original by postal mail within one week. Both oral and written comments are accepted at the public hearing. DEQ prefers that comments be provided in writing, along with any supporting documents or exhibits. All testimony, exhibits, and documents received are part of the public record. Please note this proposed plan is being concurrently reviewed by EPA.

To review proposal: The proposal and any supporting documents are available on the DEQ Air Public Notices for Plans website at http://www.deq.virginia.gov/air/permitting/planotes.html. The documents may also be obtained by contacting the DEQ representative named below. The public may review the documents between 8:30 a.m. and 4:30 p.m. of each business day until the close of the public comment period at the following locations:

1) Main Street Office, 629 East Main Street, 8th Floor, Richmond, VA, telephone (804) 698-4070, and

2) Valley Regional Office, 4411 Early Road, P.O. Box 3000, Harrisonburg, VA.

Contact Information: Deb Medlin, Department of Environmental Quality, 4411 Early Road, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7809, FAX (540) 574-7878, or email debbie.medlin@deq.virginia.gov.

STATE LOTTERY DEPARTMENT

Director's Order

The following Director's Order of the State Lottery Department was filed with the Virginia Registrar of Regulations on September 1, 2011. The order may be viewed at the State Lottery Department, 900 East Main Street, Richmond, VA, or at the office of the Registrar of Regulations, 910 Capitol Street, 2nd Floor, Richmond, VA.

Director's Order Number Eighty (11)

Virginia Lottery's "New Year Bonus Sweepstakes" Final Rules for Game Operation (effective on August 31, 2011, and remain in full force and effect unless amended or rescinded by further Director's Order. Upon the effective date, the rules supersede and replace any and all prior Virginia Lottery "New Year Bonus Sweepstakes" game rules.)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Reimbursement of Incontinence Supplies by Contract

Notice of Intent to Amend the Virginia State Plan for Medical Assistance (pursuant to § 1902(a)(13) of the Act (USC 1396a(a)(13))

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to reimbursement for incontinence supplies.

Effective January 1, 2012, the Commonwealth of Virginia plans to reimburse incontinence supplies through a contractor selected by competitive bid as directed by Item 297 VVV of Chapter 874 of the 2010 Acts of Assembly and under the authority of § 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d). This contract is expected to save the agency $1.7 million annually and to improve the delivery of incontinence supplies to Medicaid members who require such services. Comments can be mailed to or copies of proposed changes can be requested from Carla Russell, Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA 23219.

DMAS will provide copies of its regulatory action to all requesters. Please forward your written request to the Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA, 23219. Further information is also available at www.townhall.virginia.gov.

Contact Information: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, TDD (800) 343-0634, or email brian.mccormick@dmas.virginia.gov.

BOARD FOR WASTE MANAGEMENT FACILITY OPERATORS

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board for Waste Management Facility Operators is conducting a periodic review of 18VAC155-11, Virginia Board for Waste Management Facility Operators Public Participation Guidelines. The review of the regulations will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia. The purpose of the review is to determine whether the regulations should be terminated, amended, or retained in their current form.

Public comment is sought on the review of any issue relating to the regulations, including whether the regulations (i) are necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimize the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) are clearly written and easily understandable.

The comment period begins September 26, 2011, and ends on October 17, 2011.

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 David E. Dick, Executive Director, Board for Waste Management Facility Operators, Department of Professional and Occupational Regulation, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (866) 350-5354, or email wastemgt@dpor.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 the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board for Waste Management Facility Operators is conducting a periodic review of 18VAC155-20, Virginia Board for Waste Management Facility Operators Regulations. The review of the regulations will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia. The purpose of the review is to determine whether the regulations should be terminated, amended, or retained in their current form.

Public comment is sought on the review of any issue relating to the regulations, including whether the regulations (i) are necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimize the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) are clearly written and easily understandable.

The comment period begins September 26, 2011, and ends on October 17, 2011.

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Following the close of the public comment period, a report of the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; FAX (804) 692-0625; *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/cmsportal3/cgi-bin/calendar.cgi.

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/cumultab.htm.

Filing Material for Publication in the Virginia Register of Regulations: Agencies are required to use the Regulation Information System (RIS) when filing regulations for publication in the *Virginia Register of Regulations*. The Office of the Virginia Register of Regulations implemented a web-based application called RIS for filing regulations and related items for publication in the Virginia Register. The

Registrar's office has worked 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.

ERRATA

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

Title of Regulation: **13VAC5-63. Virginia Uniform Statewide Building Code (amending 13VAC5-63-120).**

Publication: 27:26 VA.R. 2858-2863 August 29, 2011

Correction to Final Regulation:

Page 2861, 13VAC5-63-120, subsection T, Exception, line 2, after "certified by" change "a Registered Design Professional (RDP)" to "an RDP"

Page 2861, 13VAC5-63-120, subsection X, column 2, line 4, after "performed in accordance with" change "§" to "Section"

VA.R. Doc. No. R11-2911; Filed September 12, 2011, 3:17 p.m.