DD Waiver Provider Manual Comments

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TO: Emily McClellan, Regulatory Supervisor

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Department of Medical Assistance Services

FROM: Teri Morgan

RE: Comment on Draft Development Disabilities Waivers (BI, FIS, CL) Services Provider Manual

I am writing to provide comments on behalf of the Virginia Board for People with Disabilities (the Board) regarding Virginia’s Draft Development Disabilities Waivers (BI, FIS, CL) Services Provider Manual, Chapter 4. The Board appreciates the opportunity to provide input on the manual. The Board offers the following recommendations to improve and clarify the DD Waiver provider manual, by service area.

**Chapter 4: Covered Services and Limitations**

**Chapter 4 DD Waiver Manual Table of Contents:**

This comment is specific to the chart identifying different service options in the DD waiver at the beginning of the manual. In the chart **Individual and Family Caregiver Training** is checked as an available service in the BI waiver, however, this service is only available in the FIS waiver. The FIS waiver versus BI waiver should be checked in the chart.

**Chapter 4 DD Waiver Manual Table of Contents:**

This comment is specific to the chart identifying different service options in the DD waiver at the beginning of the manual. In the chart **Workplace Assistance** is checked as an available serviceonly in the FIS waiver, however, this service is also available in the CL waiver. The CL waiver should also be checked in the chart.

**Diagnostic Eligibility, page 2, paragraph 1**:

This paragraph states “An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria **described in (1) through (5) above** if the individual, without services and supports, has a high probability of meeting those criteria later in life.”

**Comment**: The reference to “(1) through (5) above” is confusing because the information being referred is provided bulleted versus numbered. For clarity you may want to use numbers versus bullet points if this description is maintained.

**Slot Assignment – Community Living and Family and Individual Supports Waivers, page 12:**

**Comment:** The Critical Needs Summary (CNS) acronym should be identified before it is used.

**Slot Assignment – Building Independence Waiver, Pg. 14:**

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

**Comment**: Should the word “than” be “that”? Since the BI waiver provides a minimal level of support, *than* is not consistent with the context.

**Service Authorization, page 20, sixth bullet point on this page:**

From the manual: “DD waiver services may not be authorized or reimbursed by DMAS for an individual who: “**Is an inpatient of a hospital,** nursing facility, ICF/IID, or inpatient rehabilitation facility.”

**Comment:** Under sections 1915(c), (i), (j), (k) or section 1115 demonstrations consistent with section 3715 of the CARES Act, states can provide HCBS in acute care hospitals as long as the services provided are not duplicative of services available in the hospital setting. Does DMAS intend to add this flexibility to its waiver applications with CMS?

**Waiver Required Assessment, starting on page 24, comment specific to page 26 of this section:**

Page 26 first paragraph: “Specified affirmative responses to the items **in a through d above** require a review of the individual’s record for verification. After such review, the individual may be assigned to Level 6 (Intense and Significant Medical) or Level 7 (Intense and Significant Behavioral) regardless of scoring on other sections of the SIS.

**Comment:** It is not clear what *“items in a through d above”* is referring to? Bullet points are used in the section above versus lettering.

**Individual Eligibility for ID/DD Targeted Case Management (Support Coordination), page 34, second paragraph:**

“Any individual who meets the above diagnostic andgeneral Medicaid eligibility criteria **for** there is an individual support plan (ISP) in effect that requires direct or individual-related contacts or communication or activity with the individual, the individual's family or caregiver, service providers, significant others, and others including at least one face-to-face contact with the individual every 90 days is eligible for ID support coordination.”

**Comment**: There seems to be something missing from the bolded text. Should “for” be “and”?

**Assistive Technology, Service Units and Service Limitations, pages 51 and 53:**

Page 51, “The service unit is always one, for the total cost of all AT requested for a specific timeframe. The service unit is the total cost of the item and any supplies, or hourly Rehabilitation Engineering costs,”

**Comment:** It may be helpful to include “freight” as an example of allowable cost when determining the total cost of all AT. How the freight cost is recouped by the provider is often an area with questions and concerns.

Page 53, “Only the actual cost of material attributed to the provider of the AT is reimbursed. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered all-inclusive in a provider’s charge for the item(s),”

**Comment:** Stating that shipping, freight and delivery is not billable to DMAS can be misleading as DMAS allows these costs to be included as part of the total cost of the AT. DMAS has provided this guidance to providers and it should be clarified in the manual so that providers fully understand what is and is not allowable.

**Community Guide Services, documentation requirements, page 59:**

Third bullet: “Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. **Observations of the individual's responses to the service must be available in at least a daily note.”**

**Comment**: The sentence stating that observations of individual’s responses to the service must be available in *at least a daily note* is confusing. Community Guide services are not provided on a daily basis. As such, requiring at least a daily note is not realistic.

**Peer Mentor Supports, page 73 and page 112, Documentation in the form of, third bullet:**

“All correspondence **to** the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS,”

**Comment**: Something seems to be missing from the bullet point above. In other areas of the manual with a similar documentation requirement it reads “All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.” Perhaps “to” should be “with” on page 73 and on page 112.

**Transition Services, page 74, Allowable costs, first bullet:**

“Security deposits and the first month’s rent that are required to obtain a lease on an house, condo, apartment or other residence,”

**Comment:** Typo, “an” should be “a”.

**Transition Services, page 74, first paragraph; page 75 last paragraph:**

**Page 74**

“Individuals may receive Transition Services through the Community Living, Family and Individual Supports, or the Building Independence waivers. Individuals who leave a qualifying facility, such as Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Diseases (IMD), Psychiatric Residential Treatment Facility (PRTF), Long-Stay Hospital (LSH), or Group Home and demonstrate a **need for Transition Services have 30 days after transitioning from the qualifying facility (from discharge date) to apply for Transition Services.”**

**Page 75:**

“Transition services are not available to individuals exiting an acute care hospital. Transition Services may be authorized for a maximum of nine (9) months by the DMAS service authorization contractor prior to providing services. The funds are not available to the individual after the conclusion of the nine (9) month authorization period of time. Transition services may be requested up to two months prior to discharge. **Authorization must be obtained within 30 days of discharge from the qualifying facility. If not requested within that time frame, the individual will not be considered for transition services.”**

**Comment:** Page 74 states that an individual has *30 after transitioning to apply for Transition Services.* Page 75 states that *service authorization must be obtained within 30 days of discharge.* It’s unclear the difference between applying for Transition Services and receiving service authorization. We recommend consistent language be used in both paragraphs to avoid confusion.

**Chart at the top of page 78, page 90:**

**Comment**: We like the chart, it is a good visual. Consider doing something similar for all services.

**Benefits Planning, page 93:**

“ABLEnow. Description: Work with and on behalf of the individual and family, if applicable, to open an ABLEnow account to assist the individual pay for various expenses related to maintaining health, independence and quality of life.”

**Comment:** Typo, we believe “to” should come after individual in the above text.

**Community Engagement, page 102, Criteria/Allowable Activities:**

“In addition, group day service is available for individuals who can benefit from **the supported employment service**, but who need group day service as an appropriate alternative or in addition to the supported employment service.”

**Comment:** We believe the reference to *supported employment service* in this section is an error and should read *community engagement service*.

**Community Engagement, page 104, Allowable Activities:**

Bullet point states “Development of **living skills**,” is an allowable activity.

**Comment:** Should this be the “Development of independent living skills.”

Bullet point typo, “Access to and utilization of public transportation **and** so as to develop the ability to achieve the desired destination,”

**Comment:** “and” should be deleted after public transportation.

**Group Day Services, Service Definition/Description, page 112:**

“This service is typically offered **these services** in a non-residential setting. Group day is a tiered service for reimbursement purposes.”

**Comment:** Typo, “these services” should be deleted from the above text.

**Individual Supported Employment, page 119:**

The description of allowable activities for ISE seems similar to the activities for Customized Employment. It is not clear how the components of Customized Employment are distinguished from the general ISE activities. A recommendation that ISE follow the model of Customized Employment for individuals who would benefit from tailored job activities would be helpful and consistent with best practice.

**Workplace Assistance, page 124:**

P. 124, “Workplace assistance must not be work skills training that would normally be provided by a job coach, such as supporting the individual in learning the components of the job. Instead the service is designed to help **the individual who as learned** the basic skills of the job maintain community employment.”

**Comment:** Typo. It should likely read “*to help the individual who* ***has*** *learned the basic skills of…”*

**Group Home Residential, page 150**

“Group home settings larger than six licensed beds which became DD waiver providers prior to **May 1, 2021** may continue to operate and receive Medicaid reimbursement.”

**Comment:** Regulation 12VAC30-122-390 says “March 31, 2021” for the May 1, 2021 provided in the manual.

**Supported Living, page 176**

“This denotes a location in which the individual receiving support services would typically be required to move from the location in order to choose a different provider for the type of services provided in that setting, since the site is leased or sublet to the individual by the provider-owner and continuation of supports at that site is dependent upon receiving services from the provider-owner.”

**Comment:** The interpretation written in the manual conflicts with DBHDS staff’s interpretation that the DD waiver regulations allow an individual to retain and exercise tenancy rights while using Supported Living Services. This conflicts with plan to allow use of SRAP for Supported Living services.

**Independent Living Services, page 155**

Individuals generally receive up to 21 hours of IL supports per week (Sunday through Saturday) in the individual’s home or community settings. Because this service is billed on a monthly (or partial month) basis, if the individual does not receive the full 21 hours one week due to a documented reason (e.g., vacation, hospitalization, illness, refusal), additional hours may be provided, if the individual has a documented need, another week in the month.

**Comment**: We suggest clarifying that the limitation of 21 hours per week is based on the rate model rather than a cap in regulation.

**Shared Living, page 164**

To increase provider awareness, VBPD recommends adding that Transition funds may be available to an individual moving into their own home. Additionally, we recommend emphasizing that siblings and other family members without legal responsibilities to the individual may be roommates in Shared Living.

**Personal Assistance: Agency-Directed and Consumer-Directed Services, page 189**

Page 189 of the draft manual describes **Exemption of Nurse Delegation Requirements in the CD Model.**

For CD services, the Code of Virginia § 54.1-3001(12) states: “any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks” is exempted from the Nurse Practice Act and nurse delegation requirements.

Key requirements for the exemption from nurse delegation requirements, which must be performed in accordance with 18VAC90-19-240 through 18VAC90-19-280

· Applies to consumer-directed services only,

· Applies to tasks that are “typically” self-performed,

· The individual receiving service must be capable of directing the attendant in the appropriate performance of the task,

· The individual must live in a private residence,

· The individual must be unable to perform the tasks due to a disability.

**Comment:** The VBPD recommends that DMAS follow the key requirements for the exemption of nurse delegation and allow a provider of CD personal assistance services to support the prescribed use of medication, including assistance with medication administration,  in cases where the medication would normally be self-administered by the individual but for their disability (for example, placing pill-form medicine on an individual’s tongue, support with the use of a metered-dose inhaler).

Some states, such as Louisiana, refer to such support as “Self-Guided administration of medications” and describe it as follows: *The client may not physically be able to self-administer medications or perform other health care tasks for themselves but can accurately guide the worker through the process to do it for them. The role of the worker in client guided care is limited to performing the physical aspects of health care tasks such as administration of medication under the guidance of the client for whom the tasks are being done.*

The Nurse Practice Act explicitly exempts this type of support, and it is allowable under the key requirements detailed in the manual. If an individual receiving CD personal assistance services is capable of directing the attendant in the appropriate performance of self-guided administration of medications, they should be able to do so as part of the personal assistance service. Not allowing such support effectively excludes many people from CD services who are otherwise capable of directing their health care tasks as described in the NPA. It is a barrier to full participation in community life, achieving greater independence, and self-determination.

**Consumer Directed Services and Service Facilitation, page 204**

The support coordinator must document in the individual's record that the individual will serve as the EOR or that there is a need or desire for another person to serve as the EOR on behalf of the individual.

**Comment**: We recommend that the manual clarify that EORs (including those other than the individual receiving services) should be assessed for their ability to fulfil EOR responsibilities using DMAS Form 95-A. This can be clarified in the documentation referenced in the above sentence.

The Board looks forwarded to continuing to work with DMAS, DBHDS, and other stakeholders on the HCBS services system. Thank you for the opportunity to provide input.

CC: Alexus Smith, Chair of the Virginia Board for People with Disabilities