What is a Customized Rate?

Effective June 1, 2017 CMS approved a waiver amendment allowing providers to apply for a customized rate for individuals who meet certain criteria as described within this document. Providers will be eligible to apply for a customized rate under the current waiver system by accessing the customized rate application located on the DBHDS website. If approved, a rate unique to the individual and/or service will be developed based on eligibility criteria and the individual's demonstrated need. Individuals eligible for a customized rate must have documentation to demonstrate that they are outliers to the current rate structure and must meet certain criteria as described in this document.

- ***A customized rate will be determined on select criteria as described below:***
  - **The individual has exceptional medical support needs** that outweigh the resources available within the current waiver rate structure **and/or**
  - **The individual has exceptional behavioral support needs** that outweigh the resources available within the current waiver rate structure.

- ***As a result the individual may qualify for:***
  - **Higher level staffing ratios** of 1:1 or 2:1 to ensure the safety of the individual and others around them.

And/or

  - **Higher credentialed direct support staff** to ensure proper supports is given. This means that direct support professionals are required to have a higher level expertise in order to provide specialized supports to the individual such as:
    - *a college degree **or***
    - *specialized licensing/certification such as CNA, RBT **or***
    - *specialized training **or***
    - *any combination of the above or significant experience working with the population*

And

  - **Increased programmatic costs** associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individuals exceptional support needs are carried out in a safe and effective manner. This supervision must be provided by staff with a higher level of expertise than routinely required by Qualified Developmental Disabilities Professional (QDDPs). To qualify, staff must possess:
    - A **Master's level degree or**
    - **Bachelor's degree with additional certifications** in specific areas of expertise, e.g., BCBA license)

- **This expertise is not available through contracting for professionals which are Medicaid waiver vendors.**

And

- **General Support Services- (Sponsored Residential Services Only)** associated with the individuals exceptional behavioral and/or medical support needs which may warrant additional funding to be paid to the sponsored residential provider. This funding is not intended to supplement or replace supports provided by the sponsored home, nor serve as respite.

What Services are Eligible and Who Can Apply?

- ***The following services are eligible for the customized rate***

Family & Individual Supports Waiver	Community Living Waiver
Community Coaching	Community Coaching
Group Day	Group Day
In-home Supports	In-home Supports
Supported Living	Supported Living
	Group Home
	Sponsored Residential

- ***How is a customized rate determined?***

  - A team of medical, behavioral, integrated supports, service authorization, and regional supports experts comprise the Customized Rate Review Committee (CRRC).
  - The CRRC will meet to review the provider's application and accompanying supporting documentation to determine individual/provider eligibility based on outlined criteria.
  - Should the team determine that the individual's needs cannot be met within the current rate structure; a rate methodology will be used to determine the individual's customized rate.
  - Providers who have not maximized all waiver services may be ineligible for a customized rate.

- ***Rate Methodology***

  - A ***fixed rate*** is defined as a rate that is pre-determined based on either higher level of staff credentialing or a higher staff to individual ratio of supports, or both being required.

- A ***flexible rate*** is defined as a rate that is individually determined and is variable based on eligibility criteria such as the number of hours of increased staffing, increased level of programmatic oversight, and/or increased level of direct support credentialing required.

For the following services a fixed rate methodology will be used

- **In-home Supports** customized rates can be approved for the following:
  - Higher rate for 1:1 staffing
  - Higher rate for 2:1 staffing
  - Higher rate for specialized staffing
  - Rate range: ROS: $27.67 - $47.00/hr.
  - Rate range: NOVA: $32.56 - $55.89/hr.

- **Community Coaching** customized rates can be approved for the following:
  - Higher rate for 1:1 staffing
  - Higher rate for 2:1 staffing
  - Higher rate for specialized staffing
  - Rate range: ROS: $31.62 - $55.28/hr.
  - Rate range: NOVA: $36.07 - $64.72/hr.

- **Group Day** customized rates can be approved for the following:
  - Higher rate for 1:1 staffing
  - Higher rate for specialized staffing
  - ROS: $27.88 - $30.35/hr.
  - NOVA: $32.34 - $35.48/hr.

For the following service a flexible rate methodology will be used

- **Sponsored Residential** customized rates can be approved for the following:
  - General Support Services
  - Rate Individually determined

- **Group Home** customized rates can be approved for the following:
  - Additional hours of 1:1
  - Additional hours of 2:1
  - Higher qualified staffing costs
  - Higher programmatic costs
  - Rate is Individually determined

- **Supported Living** customized rates can be approved for the following:
  - Additional hours of 1:1
  - Additional hours of 2:1
  - Higher qualified staffing costs
  - Higher programmatic costs
  - Rate is Individually determined

Who can apply for a Customized Rate?

- Any provider supporting an individual assessed to have support needs at **levels 6 or 7**

Or

- Any provider supporting an individual assessed to have support needs at **levels 1-5** who have been verified by a Community Resource Consultant (CRC) according to the following process:
  - Once an application is received, a CRC will contact the provider to schedule a call and/or site visit. The call and/or site visit will be conducted by DBHDS staff who will validate the criteria included in the customized rate application.
  - During this call and/or site visit the provider will be asked to demonstrate that all waiver and community resources have been maximized.
  - Following the call/site visit, the CRC will make a recommendation based on his/her findings to (1) move the application to the RST for verification that all resources have been explored **or** (2) move the application to the Customized Rate Review Committee (CRRC) for review **or** (3) deny a customized rate.
  - If the CRC moves the application to the CRRC, a final review will be conducted, at which point it will be determined if a customized rate is approved.

How Can a Provider Access the Customized Rate?

- ***Application*** **–** An application to apply for a customized rate can be located on the DBHDS website: WWW.DBHDS.Virginia.gov. In addition to the application, providers will be **required to submit a staffing plan using the DBHDS template**, also located on the DBHDS website.

- ***Submission-*** Providers should send a request for a secure email prior to application submission. Once a secure link is received, applications should be submitted electronically to: DBHDScustomizedRate@DBHDS.Virginia.Gov. Upon submission, the application will be validated to ensure all application components have been met. Providers are requested to submit the customized rate application in its original word format. One application should be submitted per email sent.
- ***Providers will be required to submit the following documentation as applicable:***
  - ISP Parts I through IV and the provider-completed Plan for Supports (Part V).
  - Behavioral Support Plan, where applicable.
  - Behavioral Data, where applicable (history of crisis, frequency of interventions required, quantifiable data).
  - Health supports data, where applicable (Medical reports, protocols, specialized supervision data, nursing care plan. Seizure logs).
  - Most recent quarterly.
  - Staff credentials (Copy of certifications and degrees for all employees who will provide supports to the individual for which a customized rate is requested and who meet the criteria for specialized staffing for either direct support or programmatic support).
  - Crisis plan where applicable.
  - Overnight support's data
  - Staffing plan using the DBHDS template found at www.DBHDS.Virginia.gov. This template is a **key tool in determining a customized rate** and as such providers should assure that the form is completed accurately without leaving any columns within the template blank.

- It is the **provider's responsibility** to clearly demonstrate that the individual for whom a customized rate is requested has exceptional support needs that outweigh the resources provided within the current rate structure by providing all of the requested supporting documentation, and by completing the customized rate application accurately.
  - Providers submitting applications that are incomplete or without proper supporting documentation attached can be denied a customized rate.
  - Providers have the ability to re-submit an application for a customized at any time throughout the plan year.

- ***Review –*** The Customized Rate Review Committee (CRRC) will meet to review and determine eligibility for all individuals with supports needs assessed at levels **6-7**. Individuals with supports needs assessed at levels **1-6** will only be reviewed by the CRRC if the application is referred by the CRC and/or RST as applicable.
    - The provider will be contacted at least 3 days prior to the review by the CRRC to give notice of the review date. The provider will be **requested to be available during this time for a call** in the event that the team has additional questions not provided in the application.
    - The CRRC will make every attempt to meet no later than 10 business days of receipt of a completed application; providers submitting for an individual falling in levels 1-5 will incur a longer waiting period based on the CRC review and/or RST review. Applicants will be reviewed in the order in which they are received.

Application Status

- ***Application Approved-***
    - Once a customized rate has been approved by the CRRC, a Notice of Action letter will be mailed to the provider informing them of the services approved.
    - The provider will be responsible for submitting a service authorization request using the following service authorization codes:

Service	Service Authorization Code
Community Coaching/Customized Rate	97127 U1
Group Day Support Services/Customized Rate	T2025
Group Home/Customized Rate	T2016
In-Home Support Services/Customized Rate	H2014 U1
Supported Living/Customized Rate	H0043 U1

Sponsored Residential/Customized Rate	T2033 U1

- Approvals are retroactive to the date of a completed application received; this date will be noted on the notice of action letter.
- DBHDS reserves the right to review an approved customized rate at any time throughout the year and make adjustments to the rate as deemed necessary.
- Providers are responsible for notifying DBHDS of any changes in the individuals support needs that would affect the continued need for a customized rate and/or result in the need in an adjustment to the customized rate.

➢ ***Application Denied-***

- Providers requesting a customized rate for an individual can be denied based on the following:
  - Exceptional support need not demonstrated.
  - A need for 1:1 or 2:1 staffing not demonstrated.
  - A need for higher qualified staffing not demonstrated.
  - A need for increased programmatic oversight not demonstrated.
  - The Customized Rate Review Team has determined that the requested service needs can be met within the individual's current level and tier or through the use of other services available to the individual within the Medicaid program.
  - Proper supporting documentation was not submitted or an incomplete application and/or incomplete staffing plan was not submitted.

- Providers will be notified via standard mail of the denied customized rate with an explanation for the denial.
- **This agency is required to inform you of your right to appeal**, based upon State and Federal codes (12 VAC [Virginia Administrative Code] 30-110-70 through 12 VAC 30-110-90) and Federal regulations (42 CFR [Code of Federal Regulations] 431).If you wish to appeal a denied customized rate a, you must file a written notice of appeal with the DMAS Appeals Division within 30 days. The appeal must be sent to:

APPEALS DIVISION
Department of Medical Assistance Services (DMAS)
600 East Broad Street, Suite 1300
Richmond, VA 23219

Annual Reviews

- ***Provider Responsibilities-***
  - A request for an updated application and supporting documentation will be sent to the provider at least 60 days prior to the annual review date.
  - The annual review date will be based on the individual's service plan year.
  - The provider will have 30 days to respond to the request for an updated application and supporting documentation.
  - It is the Providers responsibility to provide supporting documentation and an updated application indicating the need for a continued customized rate. Providers who fail to submit the requested information will not be authorized for a customized rate for the following plan year.
- ***The information that will be required for annual reviews is as follows:***
  - An updated application for the customized rate
  - Medical/Behavioral quarterly update (most recent 2)
  - Behavioral data for the past 6 months where appropriate
  - Any medical protocols implemented since original review
  - Any hospitalization records since original review
  - Record of inpatient/outpatient crisis services since original review
  - Updated Crisis Plan (if changed)
  - Copy of staffing credentials for any staff hired throughout the plan year as a result of the increased funding provided by the customized rate
  - Updated staffing plan using the DBHDS created template
  - Providers will be responsible for indicating how the previous year's customized rate has been utilized to provide the approved service(s).
- ***Possible Outcomes of an Annual Review:***
  - Based upon the submitted annual review application and supporting documentation the committee can decide to:
    - Make no changes to the customized rate
    - Reduce the customized rate

- Increase the customized rate
- Terminate the customized rate