



My Life My Community Q&As

This document contains questions and answers related to the My Life My Community (MLMC) implementation process. The answers reflect the current status regarding MLMC implementation across eleven topic areas. Answers will be updated as new information is available.





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General Questions

Q1: What support will be available in the coming months as we begin new services under the waivers?

A1: We have scheduled MLMC Stakeholder Calls through March 2017 (every other week beginning January 4th 2017). See the [DBHDS Stakeholder Call Schedule](#) on the DBHDS website. WaMS training will continue to be available to providers and support coordinator/case managers into the new year.

Q2: When do we anticipate having the manual for the new regulations?

A2: The manual is expected in spring 2017.

Q3: Until the new manual comes out, is it safe to assume that providers should follow the manual that is closest to the new services until the manual comes out and if audited from 9/1 until the new manual comes out will auditors know that we did not have the new manual to follow?

A3: The regulations provide the majority of the information needed. Your notes, documentation and ISP will be the same. Regulations are what auditors are using, not a provider manual. Auditors will be using the regulations/manual from the time frame that they are reviewing.

Q4: Are the new regulations out?

A4: Yes. There are 5 sections out. There is a new section in the 500s about the competencies and then the 3 sections that address the amended waivers. They are all up on town hall and ready to review. The emergency regulations can be accessed online at the following link:
<https://townhall.virginia.gov/L/ViewStage.cfm?stageid=7420>

Q5: Can you provide an update on DSP and staff training?

A5: The updated training for Supervisors is available on the Learning Management System. Current supervisors had 120 days beginning on 9/1/16 to complete the basic requirements which include reviewing training materials, passing the test and signing the assurances. Supervisors have 180 days to meet the advanced competencies through 2/28/17. Currently qualified DSPs will have 180 days to complete the updated training and meet competencies through 2/28/17. See the Medicaid Memo dated 9/1/16. Guidance and information regarding the orientation requirements is available under Competencies & Training at <http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/provider-development> or online at http://www.partnership.vcu.edu/DSP_orientation/.

Q6: When you say Emergency Regulations, are you talking about licensing or changes in the waivers?

A6: Regulations related to the amended waivers, not licensing.

Q7: How many people are on the combined waitlist?

A7: As of 1/30/17 the total count is 11,291. Before they were combined, (as of July 2016) the ID Waiver Waitlist was 8,444 and the DD Waiver Waitlist was 2,230.

Q8: What are the plans to deal with the waitlist since those who were on the DD Waitlist are now lower?

A8: The wait list is no longer chronological, so a person is not “lower.” It is prioritized by need with the highest priority being screened for new slots. The list is large, but Virginia has managed two lists and requested slots for both lists from the General Assembly for quite some time. Merging the two lists doesn’t necessarily change the overall need.

Q9: How do we get more slots?

A9: A parent or concerned advocate can get in touch with their legislator since the number of slots is determined by the General Assembly.

Q10: How many slots can be expected next fiscal year?

A10: Next year we expect: 25 FIS slots and 325 CL slots, however, funding must first be approved by the General Assembly and CMS.

Q11: 200 slots were made available for people on the DD Waiver Waitlist effective 9/1/2016. Why was there nothing similar for people on the ID Waiver Waitlist?

A11: The DD WL has always been chronological, so merging the waivers was a significant change in their waiting list. It was felt that those at the top of the list should have access to slots. #1 and #2 chronologically may be Priority 3, so the chance of receiving a slot becomes much more distant. The ID WL has always been managed by urgency, and the new priority categories are very similar.

Q12: Will there be any new Building Independence (BI) Waiver slots?

A12: Not at this time, there were no additional slots specifically designated for BI, however, the Day Support Waiver already had some openings that can be used.

Q13: Currently there are people on the CL waiver who either receive a low number of in home hours or CD/PA services. At some point there was discussion about talking with families about switching to the FIS waiver to free up a comprehensive slot. How would a reallocation process go to get what is appropriate to a person’s needs?

A13: To be very clear, neither DMAS nor DBHDS will force anyone off one waiver to another waiver. If someone is not fully utilizing services on their waiver, it would be very appropriate for the team to discuss it with person and family and determine if they are willing to have needs met by another waiver. These discussions need to happen with families’ agreement/ choice.

Q14: Is it true that if we are not looking for a group home at this time, we could not be offered a Community Living slot?

A14: No.

Q15: Is there a waiting period that will increase once the waivers have merged?

A15: It is never too late to make your needs known to your local CSB. Contact them and let them know you are interested in having a DD Waivers screening. They will complete the VIDES and request certain documents to determine the priority of need. If all the criteria are met, the individual will be placed on the waiting list.

Q16: Is this like DARS?

A16: This is different. When you are screened for the DD waivers, you are not also screened for DARS.

Q17: For school aged kids that leave school services early (prior to the end of IDEA eligibility), does this mean they cannot meet priority one criteria at any point?

A17: They would not qualify for that category until age 22 when IDEA services would normally end. Students need to take advantage of their IDEA services.

Q18: If a child has a waiver slot, there is nothing that prohibits them from leaving school early, correct?

A18: Medicaid is the funding source of last resort. Other funding options still must be explored, even when there is access to a waiver.

Q19: Is anyone not assigned to Priority 1 status ever considered for a waiver slot?

A19: Not until all individuals in the state who are a Priority 1 are served.

Q20: Priority 1 guidelines are extremely concerning. A person / family must be in a dire situation to be considered for a slot. Is there any hope for our children over 27?

A20: Of course! We are required to give slots to individuals who have the greatest need however; it is always a good idea to inform your support coordinator of your child's interest in independent living situations or a VHDA housing voucher, if these are available in your area. Until that time, IFSP can be used and some CSBs have funding that can be used for supports.

Q21: What is the process of switching someone to the Community Living Waiver?

A21: The CSB will need to notify DBHDS to request a reserve slot as well as provide information as to why the reserve slot is needed. Please use the Reserve Slot Request Form dated 10/24/16, which is available on the DBHDS website under Case Management.

Q22: Can waivers be traded in an emergency situation?

A22: This will have to be looked at on an individual case by case basis.

Q21: If a person who has the FIS Waiver is at REACH due to a crisis and cannot return home, how can they access the CL Waiver so that they can move into a group home?

A21: There are reserve slots that will allow some movement but they are very limited. While the FIS Waiver does not include group homes or sponsored homes, it does have supported living services which are provider-operated apartment settings. The FIS waiver also includes In-home Support

services. Please consider other options before automatically requesting to move to a different waiver.

Q22: If a person is living at home and has the FIS Waiver, and her caregivers die, and she cannot access a CL slot, will she be stuck in a nursing home?

A22: DBHDS and DMAS would work with you and case manager to determine needs and the appropriate waiver.

Q23: How can a group home provider adjust our license to a four person group home plus one respite bed?

A23: Contact the regional licensing manager and discuss this with them.

Q24: When submitting an ISAR, SA said they need a schedule. Is that a requirement now?

A24: Yes. The schedule is part of the providers Plan for Supports. At this time, the only exceptions are Service Facilitators or agencies utilizing the DMAS 97 A/B or nurses utilizing the CMS 485. In these situations, the DBHDS Personal Preferences Tool is required in order to meet the person-centered plan requirements of the DD waivers.

Q25: Can you clarify what type of documentation is needed for the competencies? What do you need for training? I was told that you can put that you observed the training, is that correct?

A25: The checklist formats are available and describe expectations for documentation. For new hires, proficiency must be confirmed in the last column by a supervisor for DSPS and the agency Director (or designee) for supervisors with 180 days of hire. A transition period was implemented for currently qualified staff, which included until January 12, 2017 for supervisors to meet basic competencies and February 28, 2017 for supervisors to meet advanced competencies. Current DSPS have until February 28th, 2017 to meet basic and advanced requirements. The type of training received should be indicated on each checklist and correlate with training documentation in the personnel record.

Q26: Is there a time limit on when staff have completed past trainings that supports meeting competencies in the checklist?

A26: There is no time frame for when the training was received. You can use past training if you have documentation of the training.

Q27: Is there a new VA Medicaid Web Portal site?

A27: This has not changed.

Q28: How can someone find a service they need?

A28: You should always work with your Support Coordinator / Case Manager to locate services. On August 26, 2016 a provider survey was initiated to collect information about available services. We will map out where services are available and share this information with individuals and families.

Q29: Can an individual appeal their waitlist prioritization?

A29: Appeal rights will be provided when a status is changed to a lesser priority.

Q30: Are periodic supports available under the community living waiver?

A30: The amended waivers for individuals with developmental disabilities do not include PS. Providers that had PS hours approved for an individual in the ID Waiver (other than Group Home and Supported Living residential providers that now bill for a daily unit) will still have those hours in VAMMIS until a new service authorization request is submitted. Sponsored Residential providers will have previously approved PS hours available and may submit requests that include PS hours until 12/31/16. Back-up plans should be utilized and emergency requests for an increase in hours should be submitted with justification as soon as possible so that the additional hours can be added to the monthly amount of authorized hours. Please refer to the Guidance for Semi-Predictable Events.

Q31: Do we send the certificate for the DSP supervisor test to Billie Anderson to get the Answer Key?

A31: Yes, at billie.anderson@dbhds.virginia.gov.

Q32: Do LCSW supervision hours count toward supervisor competencies?

A32: The competency checklists are tools that collect evidence and confirm that competencies are met. Training related to the competencies must relate to the competency areas. If documentation substantiates that it does and is recorded in the personnel record, it may be used.

Q33: Are the advanced competencies required at 5, 6, and 7 for existing supervisors?

A33: Supervisors can complete the advanced competencies along with DSPs in the last 60 days leading up to the February 28th, 2017 deadline for the transition of existing qualified staff.

Q34: The environmental modification program is a burden and it creates difficulty in moving into an apartment. No contractors wanted to provide this service in Tidewater area. We are finding that the CSB is not the problem, but access to a contractor is the problem. Is there a listing of providers that will work on EM?

A34: Your local CSB can support with this and most work with vendors. They have to work through the State process as well as the CSB requirements, which can add to the time and difficulty. In terms of developing the provider network, DBHDS is mapping out reported service options, which will be available in an online searchable database in early 2017. Link to current list: http://www.dmas.virginia.gov/Content_atchs/ltc/ltc-wvr_atlist.pdf

Q35: For people on the wait list, what are their options for CM services while they are on the wait list?

A35: Individuals with DD on the waitlist will be offered a choice of CM from the CSB in their region, CSBs with a Memorandum of Agreement (MOA), and a private provider agency. Individuals on the ID on the waitlist will be offered choice of CM for their CSB in their region and CSBs with an MOA.

Q36: If I have a private Case Manager, can I keep that person as my provider?

A36: The CSBs are working with private providers to develop contracts. Each DD CM who meets requirements will have a contract with the CSB for the individual they support.

Q37: Where can I find the Q&A from the weekly calls?

A37: This document replaces previous Q&A documents. For updates, go to the DBHDS website. Choose Individual and Family then click on Developmental Services. On the left hand side, choose My Life My Community then scroll down the page and you will see Waiver Redesign Training.

Q38: Regarding the QDDP qualifications. The old guidance allowed for the equivalent experience of 5 years with no Bachelors. Is this still an option?

A38: The Federal CMS definition of Qualified Intellectual Disability Professional (or Qualified Developmental Disability Professional) DOES NOT have educational equivalency. CMS guidance makes it clear that individuals must at least have a bachelor's degree in a human services field to be designated as a QDDP, however, the licensing regulations allow for experience in lieu of education for supervisors in DBHDS-licensed service settings.

Q39: Who do we contact if CSB refuses to do screening?

A39: Call Sam Pinero at (804) 786-2149.

Q40: Can people get the prioritization confirmation document?

A40: SCs should have this for individuals identified as Priority 1.

Q41: Do we now use QMRP, QIDP, or QDDP for credentialing?

A41: QDDP - Qualified Developmental Disability Professional.

Q42: Can a person with a doctorate in psychology without a license and bachelors in English serve as a QDDP?

A42: Carrying a license is related to the federal definition in regards to operating in the capacity that requires a license. If they are not operating in that capacity, a professional license would not be required and they can serve as a QDDP.

Q43: Why were slots submitted to CMS as a separate amendment?

A43: CMS asked the Commonwealth not to submit the amendment for new slots until after the 3 major amendments have been approved.

Q44: If someone is admitted to the hospital or rehab facility, how many days can they stay before they lose their waiver?

A44: When services are interrupted due to the individual's entering an ICF/IID, NF, or rehabilitation hospital for temporary services, the support coordinator/case manager must immediately notify the LDSS eligibility worker by telephone and forward a DMAS-225 to the LDSS and DBHDS explaining the reason for the temporary discharge. If this interruption continues for more than 30 days, the slot must be retained using the Retain Slot function in WaMS. If this situation continues after the first request to retain the slot, the person's status will be reviewed at least every thirty

days to assist in making a decision about retaining or reassigning the slot.

Q45: Where can we find information on the new services, training slides, service descriptions, professional/qualifications?

A45: All are listed on the DBHDS website and in DMAS Memos. The training materials and Q&A documents are available at <http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/my-life-my-community> under “Waiver Redesign Training.”

Q46: Are the rates are being updated?

A46: No. Customized rates and the rate methodologies for some services are being submitted to CMS for review and approval. Rates are located in the final rates document at <http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/my-life-my-community> under “Waiver Redesign Information” and are listed in various DMAS memos. Rates can also be located on the DMAS rate sheet available at the following link: http://www.dmas.virginia.gov/Content_atchs/lrc/My%20Life%20My%20Community%20Rate%20File%201%20Updated%2010_28_2016.pdf

Q47: If I am a provider of a service can I provide that service in all 3 waivers?

A47: Yes.

Q48: Who gets a conditional license?

A48: Providers with current DBHDS Licenses adding additional services will be issued a conditional license for the new service. This does not trigger enhanced case management because the provider’s primary license remains intact.

Q49: What is the effective date to start using VIDES for Eligibility Determinations?

A49: September 1, 2016 when the Waiver Amendments were approved.

Q50: When will providers be required to give notice of their intention of changing licenses?

A50: This should already be happening.

Q51: Will there be provisions for grandfathering in certain providers related to licensing?

A51: No. Service Modifications will need to be done by providers to add the additional services to their licenses.

Q52: Can a new provider with a conditional license do a modification to add a service?

A52: No.

Q53: Will there need to be a separate plan for every service an individual is receiving, if all the services are being provided by one provider?

A53: DMAS is reviewing the possibility of a single plan option. At this time, separate plans are required for each separate service.

Q54: What are the documentation requirements for all of the new services?

A54: Supports and services should be documented each time they are provided as is currently required. Information will also be included in the new manual.

Q55: Is the waiver portable across the State?

A55: Yes.

Q56: Does family have to live in the home to be considered the primary caregiver?

A56: Yes.

Q57: Where can families find more information about service packages?

A57: At this time, service packages are not being implemented and information is not available.

Q58: Is the Documentation of Individual Choice Between Institutional Care or Home and Community Based Care (DMAS 459C) still required?

A58: Yes.

Q59: Is there a contact list for SC supervisors and/or IDD Directors?

A59: Contact the Virginia Association of Community Services Boards (VACSB).

Q60: Can the Medicaid Web Portal site be accessed in windows 10 or with Mac products? They don't seem to be compatible.

A60: There are no plans to make changes to the software at this time.

Q61: Do families who wish to have their loved ones added to the wait list have to disclose financial information to the CSB?

A61: At the intake, families are being assessed to determine if their loved one meets the waitlist criteria. Information regarding the individual's or families' resources may be requested if the family is requesting support coordination services. There is no financial requirement for the person to be on the waitlist. The intake person will ask about Medicaid and if application has been made.

Q62: When do the Supervisor and DSP Orientation and Competencies need to be completed?

A62: See Medicaid memo dated 9/1/16 and the DBHDS Memorandum dated 12/07/16.

Q63: Will there be written question from these calls posted online?

A63: Yes. All Q&A documents have been updated and compiled into this one complete document representing all the stakeholder calls from 2016.

Q64: Provider submitted an Enrollment Application, but it was rejected.

A64: Look at Medicaid Memo dated 8-30-16. If you still have problems, send information to Ann Bevan at ann.bevan@dmas.virginia.gov.

Q65: Are customized rates available?

A65: We have not received approval from CMS.

Q66: Has everyone received a level that has waiver?

A66: Not all have received a SIS; there are a handful left. Those without a SIS will be given a level 2, tier 2 until one is completed.

Q67: The competencies checklist now have been revamped, will the advanced competencies also be revamped?

A67: The basic and health competencies have now been updated to a new format. We are currently revising the autism and behavioral competencies.

Q68: What is considered to be the eligibility criteria that needs to be in the file for billing?

A68: The file should confirm diagnostic, functional, and financial eligibility

Q69: Can an individual access transition services to move from a family home to his/her own home?

A69: No.

Q70: What do providers do if they believe the SIS level and tier are incorrect in WaMS?

A70: Providers can contact their assigned Regional Support Specialist to discuss, but should be aware that the level and tier are not appealable. If there was a concern with the interview process, individuals can appeal within 30 business days of the date they receive the SIS® report.

Q71: Are Periodic Supports available for Personal Assistance?

A71: No. Providers can submit requests on an emergency basis and receive temporary approval for increased hours during a month. See the December 19th, 2016 Medicaid memo under “Guidance for Accommodating Semi-Predictable Events.”

Day Support and Day Services

Q80: When billing for Community Engagement and Group Day do you always bill for the hour or can you bill for 30 min?

A80: Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member; however, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

Q81: Can a residential provider be licensed for community engagement or community coaching and provide the service to individuals and group homes that they operate?

A81: Yes, a provider can become licensed for non-center based day services; however, there will be limitations to ensure that individuals have the opportunity to participate in activities with people other than those they reside with. In addition, these services are not to be used for activities that typically occur in the residential service. For example, if an individual has been going out to eat every

Friday night, converting this time to Community Engagement would not be appropriate. If a new opportunity arises outside of a person's typical schedule, Community Engagement could be requested to accommodate this opportunity. There is regulatory requirement (12VAC35-105-610 Community Participation) that individuals receiving residential and day support services shall be afforded opportunities to participate in community activities that are based on their personal interests or preferences. The provider shall have written documentation that such opportunities were made available to individuals served.

Q82: Is it possible for an individual who works 40 hours a week to also receive Community Coaching 2 hours per day on week days and 8 hours per day on the weekend?

A82: Yes, an individual may combine employment and day services up to 66 hours per week. Please recognize that Community Coaching is intended to reduce barriers to community engagement and is not solely for the purpose of providing one to one supports.

Q83: If DARS funds are available, can a person access Supported Employment under the waivers without going through DARS first?

A83: No.

Q84: Can someone who has a personal assistant at work replace that service with a Work Place assistant on July 1, 2016?

A84: Personal Assistance and Workplace Assistance are different services. If an individual only has personal care needs, Personal Assistance is the appropriate choice. Workplace Assistance would be selected when additional supports are needed to maintain employment. It is not approved solely for personal care activities.

Q85: Are there limits on how long a person can receive Workplace Assistance?

A85: No, but the provider is expected to assess for fading the service at least annually.

Q86: Can a person receive Community Engagement, Community Coaching and Group Day at the same time?

A86: Yes, An individual may combine these services to exceed not more than 66 hours per week. Community Engagement and Community Coaching are provided in the Community. Group Day can be provided in the community but can also be provided in a center-based setting. While one person can receive all three services, none can be provided "at the same time."

Q87: Is Community Coaching designed to move a person into Community Engagement?

A87: Correct. Community Coaching was developed to address barriers to participating in Community Engagement.

Q88: Can Community Coaching be utilized with Day Support Staff for higher level needs?

A88: No. Community Coaching is a service designed to address barriers to community engagement through one to one supports in the community. It should not be provided in alongside group day services as this includes center based services.

Q89: If a person is self-employed and owns their own business can they access supports?

A89: Yes. The service would depend on the supports needed/provided.

Q90: Does Community Coaching and Community Engagement, allow for supporting an individual with activities of daily living (ADLs)?

A90: Yes.

Q91: What is the main difference between Community Engagement and Community Coaching?

A91: Community Coaching is designed to address barrier to individuals participating in community engagement through reduction of the staff to individual ratio. Community Engagement ratio is 1:3 and Community Coaching ratio is 1:1.

Q92: Is it acceptable for six individuals receiving Community Engagement to go to an event with the proper ratios in separate vehicles, but end up in the same place?

A92: No. Community Engagement has a 1:3 ratio and is about the activity and not how they are transported; however, the 6 individuals could go to the same place and group day be billed instead.

Q93: With Community Coaching and Community Engagement, can we provide 2 staff to 1 individual (for someone with excessive behaviors)?

A93: Yes, but the reimbursement rate remains the same.

Q94: Who provides Work Place Assistance?

A94: Workplace Assistance can be provided by a provider with a DARS provider agreement or a DBHDS Non-Center Based Day Support License.

Q95: If receiving a non-center based day service, can the individual come to the facility for any percentage of the day?

A95: Yes, however the amount of time that they are in the facility would need to be authorized and billed as group day. Community Engagement does provide a 10% monthly allowance for planning purposes.

Q96: Is 1:3 or 2:6 the same ratio? If not, why? What about 2:2 ratios?

A96: No, 1:3 and 2:6 are not considered the same ratio for Community Engagement purposes. Because, the service is about the activity and the ability to develop naturally occurring relationships once you increase the number of individuals with developmental disabilities, you decrease the opportunity for naturally occurring relationships.

Q97: Who will be responsible for monitoring ratio size for in-home, day support, etc.?

A97: Licensing, Human Rights and DMAS QMR. The SC should also know what supports the individual is receiving. However, SCs are not responsible for enforcing the ratios, although should report if they see services not being delivered appropriately.

Q98: If Supported Employment groups are smaller on different days can the rate be easily adjusted?

A98: Group supported employment rates are based on the size of the group, which can only be adjusted with a change in authorization.

Q99: Is it ok for people to do work tasks/get paid in day support, just not a part of their outcomes and activities, correct?

A99: There is nothing in the regulations that prevents individuals from being paid during the provision of day services; however, in order to meet the HCBS Settings Rule the provider must show integration in the community. Providers must also have outcomes that meet the requirements of the allowable activities associated with day services.

Residential Services

Q100: How do we modify billing for In-home Services when the ratio changes?

A100: Submit an initial authorization based on the number of individuals supported. If the ratio changes, you will need to submit a new service authorization request.

Q101: Do residential (or other providers) need to have contracts with the CSB like the DD Case Managers?

A101: No.

Q102: How many people can live in a supported living situation/apartment?

A102: One per bedroom is advisable.

Q103: Does supported living allow the individual to live with his parents in their home?

A103: No.

Q104: Is there a limit on hours someone can receive while living in a Supported Living arrangement?

A104: No supports are available around the clock and the service is billed at a daily rate.

Q105: Do Supported Living providers need an on-site office or can they be down the street and provide a timely response?

A105: A timely response is needed.

Q106: Does the primary caregiver have to be a blood relative?

A106: No.

Q107: When providing group In-home service, do the 3 individuals have to live in the same residence?

A107: No, for example, if three individual's live near each other and choose to spend time together in-home could be provided to all three.

Q108: Can In-home supports be provided in a provider-operated home?

A108: No.

Q109: When providing in-home to two or three individuals, do we bill them at the same rate?

A109: Yes.

Q110: When providing In-home services at 1:1, do you need to change the modifier or can it wait until the annual plan?

A110: You can choose to wait until the start of the annual planning year

Q111: With Shared Living can a roommate be family?

A111: It cannot be parents, spouse or the legal guardian. Could be brother, sister, cousin, etc.

Q112: In the shared Living situation is the money given to the individual to pay for the room and board for the roommate or does the overseeing agency do this?

A112: Funds are provided to the agency that supports the individual to dispense per agreement with the roommate.

Q113: Is the shared living roommate expected to be on site 24/7

A113: No, the support provided by the roommate will be agreed upon by the individual and the roommate, and individually through a person centered planning process.

Q114: Does the gender of the roommate matter?

A114: No, there is no specification regarding gender unless the individual has a preference.

Q115: Can you receive a voucher and receive shared living?

A115: Yes.

Q116: Will there be payment to the providers who would like to be the provider agency for shared living?

A116: Yes, a flat rate administrative overhead fee is provided to the provider agency.

Q117: Who is coordinating the background checks for shared living?

A117: The administrative agency.

Q118: Can a person with a disability be the live-in roommate providing supports under the Shared Living Services?

A118: Yes.

Q119: What is the response if abuse occurs in a Shared Living arrangement? Will the administrative agency be held accountable?

A119: Mandated reporting by providers continue as required. It will be the joint responsibility of the provider agency and the case manager (TBD) to periodically monitor the safety, health and welfare of the individual as detailed will be in the provider manual.

Q120: How do you terminate a roommate agreement under Shared living when the roommate does not want to leave?

A120: Individuals receiving Shared Living services could have a variety of lease situations – i.e., some listed as “occupant” and some with full tenancy rights. This variation means that changes in each household will need to be addressed on an individual level.

Q121: Will the provider doing the administrative oversight be held responsible if something happens to the individual because the roommate was not there with them?

A121: No, however the agency is responsible for managing and tracking back-up support provisions, and contingency and risk management planning. The Support Coordinator also monitors as part of the SC responsibilities.

Q122: Will having family as a provider still be an issue for DMAS and OL? How do we support going forward?

A122: Service descriptions state when a family member can or cannot provide the service. There will still need to be justification and documentation that there are no providers available for the service.

Q123: Do you have to adjust your license to serve the new population coming (if you currently only serve individuals with ID and will begin to serve individuals with DD)?

A123: No, but updating your agencies policies and procedures and ensuring staff are qualified to support each individual’s unique needs is expected.

Q124: If a person moves from one Sponsored Residential Provider (SRP) to another SRP within the same agency, does the 344 reset?

A124: No, it does not reset with SRP’s within the same agency. But if the move is from one agency to another agency the time frames do reset. This would be a new service.

Q125: If a person moves from an SRP to a group home within the same agency? Does the 344 reset?

A125: If an individual moves from Agency A SRP to Agency A GH, this is a new authorization and a new service. This resets the 344 days.

Q126: Question regarding the 21 days in residential. Can we spread out the 21 days throughout the year by taking 3 days a month, instead of 21 at the end of the year?

A126: Yes, but be aware that those days have been taken and could impact the decision to have time away later in the year.

Q127: Sponsored Residential/Group Homes leases, who is the landlord?

A127: The agency of the sponsor and the group home provider.

Q128: What is the justification for not paying a sponsored provider for three weeks when they have someone with extensive support needs who will not be absent for that length of time?

A128: The rate study completed by Burns & Associates is based on an annual per diem rate. The annual rate is paid over 344 days at a higher rate instead of 365 days.

Q129: Can a sponsor have a respite bed as well?

A129: Not in addition to the two beds allowed. Licensing regulations would allow one respite bed and one sponsored bed. The beds could not be interchangeable (a respite bed remains only a respite bed until a change is requested) if someone has designated a respite bed on their licenses, they would always have to use that bed as a respite bed. If someone has designated two sponsored beds as such, unless they notify licensing using the appropriate forms to change their license. It is also important to note that staffing may need to be increased or supports in a home when someone is admitted for respite services, if the provider is use to only providing supports for one sponsor person.

Q130: I would like to provide sponsored services to my child because I cannot get the supports she needs. Are there regulations that state age restrictions?

A130: See chapter II of the ID Waiver Manual on the DMAS portal. The manual notes that paid supports cannot be provided by a parent to a minor child. This is a federal regulation, which will not change under the amended waivers.

Q131: As a sponsor provider we are given the family friendly version of the SIS, but it is not scored. How do we verify it is correct?

A131: First, please be aware that the "Family Friendly" version of the report is the only report that is now distributed in the state of Virginia to anyone. This includes providers and case managers as well as families. It is a very detailed formula that calculates the score. If you have questions contact your Regional Support Specialist.

Q132: Can a child go to school while living in a waiver group home?

A132: Yes.

Q133: If someone misses day support, how can a residential provider increase the plan if they are already approved for that service?

A133: The residential provider can submit a service authorization request with justification describing that the other service did not occur. The hours once approved will be added to the monthly total for the residential provider.

Q134: When a group home size changes because someone moves in or out, do we have to change the modifiers?

A134: The modifier is for the number of beds the home is licensed for. You don't make changes if you have an open bed. There would not be a change unless you completed a licensing modification.

Q135: If there is an authorization approved in a group home and the modifier does not match the current license, do we need to change the modifier now or can it wait until the annual planning year?

A135: As soon as possible after you receive the new licensed capacity, you do need to do a service modification to enter the appropriate modifier. There is an incentive if the licensed capacity is going down. If increasing, and there was DMAS review, that could result in a payback for you.

Q136: Can a person or couple receiving services who is/are married access the housing voucher?

A136: Yes, it is based on the size of the household and the total income limits.

Q137: Can the provider bill on a day when the person is in the hospital?

A137: No, this would be excluded from billing. Please watch the video at the following link to explain how the 344 day billing works. <https://vimeo.com/114981312>

Q138: How will DMAS look at General Supervision going forward?

A138: "General Supervision" or General Supports will be included in the services where tiered rates apply.

Q139: Will individuals receiving Congregate Residential Services or Sponsored services still be able to get Companion services since the billing is going to per diem?

A139: Yes.

Q140: I understand that the rate for reimbursement is based on the number of beds a program is licensed to provide services for in a specific location. But if a provider who is licensed for a 5 bed group home and used one bed as an agency directed respite bed now wants to be licensed for a 4 bed group home and a 5th bed licensed for Respite are they still seen as a 5 bed location for reimbursement?

A140: If the group home is 5 beds and one bed is a respite bed, four beds will be entered into WaMS for that provider's reimbursement.

Q141: Do licensed group homes require staff that is awake overnight?

A141: Yes.

Q142: Do residential providers receive the same pay whether an individual stays home or goes to day services?

A142: The residential rate is a per diem rate and is the same whether the individual stays home or goes to day services.

Q143: Can group homes have a month-to-month lease?

A143: Yes, but they must follow all the rules in the Virginia Landlord Tenant Act.

Q144: For the residential 344 hours, did that 344 start 9/1 and if not, when?

A144: It started 9/1 and goes until the end of the plan year, or change of service or provider.

Q145: With the 344 billing cap, I am allowed to bill for days when an individual is not in the service?

A145: You cannot bill for days when the individual does not receive services.

Q146: Under the per diem rate, is there a minimum number of hours required during the day for an individual to be counted as present? Can you bill for the whole day if the individual is only there for 15 minutes?

A146: There are no current waiver regulations on this. No lower limit has been set, but we want to ensure this is not being used excessively. Future discussion will likely be had regarding this issue.

Q147: Can two residential providers bill for the same day in the new waiver? An example would be if an individual moved from one group home to another group home.

A147: Only one provider can bill per day. This should be negotiated between the two agencies.

Consumer Directed Services

Q148: There seems to be a lack of CD providers. Will there be any push to increase CD services?

A148: A survey had gone out to all providers to gather information about services they provide and where they are located (in order to map out where services are being offered and where there are gaps). Service Facilitation is included in the survey.

Q149: Has the visit requirement for Service Facilitation changed? The application says they have changed to 2x's a year versus 30-60-90.

A149: The requirements for visits have not changed.

Q150: Will the ratio-for CD services change for individuals in the same home receiving CD, respite or personal assistance?

A150: No, these services will continue to have a 1:1 ratio.

Q151: Can the personal attendant also be the companion for the same individual?

A151: Yes. Clarification will be provided in the manual.

Q152: If the Service Facilitator is not available is it the CSB's responsibility to provide it?

A152: No.

Q153: Will CD services continue in the amended DD Waivers?

A153: Yes, they continue to be available in the FIS and CL waivers.

Q154: If a CD provider lives with the individual, can they work more than 40 hours per week?

A154: Yes.

Q155: With the waiver redesign, who will be the service facilitator now? Can you keep the same private facilitator?

A155: Yes, you can keep the same facilitator. You also have the choice of other providers

Skilled Nursing

Q156: How do we know when to provide Skilled Nursing and when to provide Private Duty Nursing?

A156: The determination of which service is most appropriate (skilled nursing or private duty nursing) requires a discussion between the physician, who must sign off on the medical necessity of the service, and the planning team including the individual, support coordinator, family/representatives and paid providers.

Distinction from Skilled Nursing: Private Duty Nursing services are services that are delivered in larger blocks of time. Some individuals currently authorized for a full shift/day of Skilled Nursing will need to be switched over to Private Duty Nursing.

Private Duty Nursing provides individual and continuous care (in contrast to part-time or intermittent) care for individuals with a serious medical condition and/or complex health care need, certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility or ICF-IID. Care is provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse.

Emergency regulations regarding service descriptions are below:

[12VAC30-120-1031. Covered services: skilled nursing and private duty nursing](#)

A. Skilled nursing services.

1. *Services description. This service shall provide part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel.*

f. The support coordinator/case manager shall assist an individual who has skilled nursing needs that are expected to be longer-term, but intermittent in nature, with accessing skilled nursing services.

B. Private duty nursing services.

1. *Service description. Private duty nursing services means individual and continuous nursing care that may be provided, concurrently with other services, due to the medical nature of supports required by individuals who have a serious medical condition or complex health care needs, or both, and which has been certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital, nursing facility, or ICF/IID. This service shall be rendered to the individual in his residence or other community settings.*

Q157: What do we need to do to start offering Private Duty Nursing? Do we need to become licensed by DBHDS to provide nursing services in a group home?

A157: To change services from Skilled Nursing to Private Duty Nursing or to introduce Private Duty Nursing services, complete a DMAS Provider Participation for Private Duty Nursing. You will need to submit your nurse's license in order to bill for this service. DBHDS does not license nurses.

Q158: Is there a per day cap on private nursing reimbursement?

A158: No. The length of time nursing services are provided is dependent on the needs of the individual and what is ordered by their physician.

Q159: Can private duty nursing be provided in group homes where the daily rate applies and/or at the same time as other wavier services?

A159: Yes. Due to the medical nature of these services, they can be provided alongside other services as long as the activities are distinct and separate.

Q160: Is it the physician's order that will determine the use of Registered Nurse or Licensed Practical Nurse?

A160: Yes.

Q161: Who decides that a nursing duty can be delegated?

A161: The delegating nurse, per the Nurse Practice Act.

Q162: Is congregate nursing an option?

A162: No.

Q163: How often do skilled nursing services have to be reauthorized by the physician?

A163: The time frame for the authorization of skilled nursing is determined by the physician and documented on the DMAS 485. As part of the order for skilled nursing s/he will identify a start and end date. If nursing services are still required past the end date, a new DMAS 485 will need to be obtained.

Q164: Are Periodic Supports available for Private Duty Nursing or Skilled Nursing?

A164: At this point no, however adjustments can be made to the service authorization as needed to accommodate unplanned events. Make sure there is a back-up plan for when things happen outside of the normal schedule. See the December 19th, 2016 Medicaid memo under "Guidance for Accommodating Semi-Predictable Events."

Q165: Can Skilled Nursing be provided by a Sponsored Residential Provider?

A165: No.

Q166: Can a Registered Nurse bill waiver for delegating a specific medical task to an LPN?

A166: Yes, education and monitoring are billable services.

Q167: If a nurse has more than 5 years of experience but no bachelors' do they qualify as a QDDP?

A167: No, however, 5 years of experience would suffice for equivalency under the Office of Licensing requirement for supervisors if there is no bachelor's degree.

Q168: The rate in the memo regarding Skilled Nursing is lower than the rate that was published in the Burns rate model. Is this the rate just for now or will it increase?

A168: The rate from Burns and Associates was a suggested rate that was not approved by the General Assembly. The rate in the memo is the rate that will be used.

Q169: Can skilled nursing services be used to provide training, education and oversight of physician's orders to day support providers supporting people who are coming out of the institution?

A169: Yes.

Q170: Can someone have the Community Living Waiver and still live in an apartment?

A170: Yes.

Therapeutic Consultation

Q171: How do you bill for writing plans under Therapeutic Consultation?

A171: Time considerations for plan writing and assessments are built into the new rates rather than being identified as billable activities.

Q172: Is there a place I can find a list of providers who offer behavior supports through therapeutic consultation?

A172: There is a list of Positive Behavioral Support Specialists online. Go to www.personcenteredpractices.org. Click on Virginia Positive Behavior Support on the left hand side. The second link says find endorsed providers. You can also request this information from your SC/CM.

Q173: Will the DSP training be required for therapeutic consultation providers? We have been cited for not having it, will there be clarification?

A173: The DSP Orientation is for DSPs and their Supervisors. If the therapeutic consultant also supervises DSPs, they would need the orientation. Please see DMAS memo dated 9/1/16.

Q174: Are there any limits on the length of time Therapeutic Consultation can be provided?

A174: There are no limits in the regulations at this time.

Q175: Under the reimbursement scale for therapeutic consultations, what credentials are you considering a therapist and what are the credentials for "other"? Are Registered Behavioral Technician's able to provide supports and bill under Therapeutic Consultation?

A175: Therapist: Speech and Language Pathologist, Physical Therapist, Occupational Therapist, Recreational Therapist Other: Positive Behavioral Support Facilitators, LPCs, LCSWs, and Rehab Therapists. RBT's are not approved to bill for Therapeutic Consultation.

Q176: Does Therapeutic Consultation require new service authorizations for every individual as a result of the transition to the amended waivers?

A176: A new authorization is only needed if the approved rate is incorrect for the staff providing the service.

Q177: Are Therapeutic Consultation rates determined by credentials?

A177: Correct.

PERS

Q178: Are Personal Emergency Response System (PERS) services available to people who receive residential services?

A178: PERS is not available to individuals receiving residential supports that are reimbursed on a daily basis (e.g., group home, sponsored or supported living residential services).

Crisis

Q179: Under the redesign, an individual can receive 90 days of crisis stabilization which is more than the 60 currently allotted. For people who used the 60 days, will they have the 30 left after 9/1?

A179: Under the new waiver and because it's a new procedure code, everyone is starting over on 9/1 so you will not be penalized for days used prior to 9/1. Limits included in the emergency regulations are detailed below:

Per the emergency regulations:

Medically necessary crisis prevention may be authorized for up to 60 days per ISP year.

Medically necessary crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year.

Medically necessary crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year.

Q180: When supporting someone in crisis who has a DD waiver and no longer has viable housing options, how do we change the waiver so that he can move to the CL waiver and how soon can this occur?

A180: There are reserve slots that will allow some movement but they are limited. DBHDS has developed a process where vacated slots can be used for people waiting to move between waivers. The forms to request a change in waiver are online at DBHDS under Case Management.

If the individual has a FIS Waiver that does not include group homes or sponsored homes, it does have supported living which is an apartment style set up and includes In-home. We caution against the idea that people automatically need to have group home services. Please consider other options before automatically requesting to move to a different waiver.

Q181: Are there any incompatible services with Crisis Support Services?

A181: No.

Q182: Is there an option for Emergency Services at a CSB to bill any waiver services?

A182: No.

Q183: Can a PBS consultant or an ABA consultant provide all crisis services?

A183: Yes, but they must be affiliated with an agency that is licensed to provide these services.

Q184: Can other providers beside REACH provide Community-based and Center-based crisis services?

A184: Individuals have the choice of any provider who meets the criteria and is licensed.

Q185: If all of the days of an authorized crisis period are not used, how do we handle the non-used days?

A185: Provider's only bill for hours actually used. Terminating the service early provides the person with the rest of the unused days, which would be available for future use.

WaMs

Q186: When completing Assistive Technology and Environmental Modification Requests in WaMs, will the SC need to log out and back in as a provider to complete the entry?

A186: You still have to go in as the role you are completing. With the dual role you will have to assign those roles to the appropriate staff, SCs will need to have the provider ISP approval role. If you need assistance call the WaMs help desk.

Q187: Why does it take so long to get approval for environmental modifications?

A187: It depends on what the SC writes as justification. Sometimes there may be a need for more information. DBHDS has hired additional SA staff to assist and are working on developing training for SCs on the processes of justification.

Q188: When are billing units rounded daily, weekly or once prior to submitting the bill?

A188: It is rounded once a month regardless of number of billing submissions each month.

Q189: How do support ratios affect billing?

A189: Services requiring ratios should not be billed unless the appropriate ratios are provided.

Q190: Will DMAS be offering training on billing?

A190: Billing training is available on the DMAS website at the following link:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderTrainingLibrary>

Q191: Does the Support Coordinator (SC) have to adding individuals to various providers in WaMS?

A191: Yes. SC's are required to assign providers in WaMS.

Q192: Does WaMS assign the person to the SC?

A192: CSBs and SCs have access in WaMS for the individual they support.

Q193: Will the case loads remain the same for the SC? Will WaMS impact the caseloads?

A193: Designation of individuals to the SC caseload is made by the CSB not WaMS.

Q194: Follow-up of the implementation of WaMS; will private providers be restricted from seeing all the cases assigned to the CSB?

A194: When the provider signs on, they will only see those assigned to them

Q195: Will there be additional WaMS training opportunities for SCs and providers?

A195: Yes DBHDS has two training staff dedicated to providing webinars and trainings related to WaMS during the transition. Recorded training videos, a manual and WaMS helpdesk contact information is available online at:

<http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/my-life-my-community-waiver-redesign>

Q196: Will the SC be responsible for entering all the information into WaMS?

A196: Providers currently have the ability to initiate service authorization (SA) requests and SCs will approve.

Q197: How can I better understand the different roles that are set up in WaMS?

A197: If you need help understanding roles or adding your staff, call the WaMS helpdesk at 844-482-9267.

Q198: Will CHRIS reports be in WaMS?

A198: No

Q199: The WaMS system is not accessible with some versions of Windows Explorer - how soon can that be fixed?

A199: WaMS requires the use of fairly recent browser versions: IE 10 and above, Google Chrome 50.x and above, or Firefox 40 and above.

Q200: There was an email that indicated a "WaMS Phase 2." What does that mean?

A200: WaMS is being implemented in three phases with increasing functionality across these phases through March of 2017.

Q201: Can DD Case Managers see the individuals they support when they log into WaMS?

A201: CSBs need to assign individuals to DD Case Management providers to enable access.

Q202: The WaMS manual lists various roles. Will these roles be defined in the manual?

A202: The WaMS training documents are navigational guides which are meant to show you where to go and how to perform various functions. The guide will not go into the responsibility of SC or provider nor identify what roles or access they have within the system. Training from your direct supervisor will show you what you are responsible for.

Q203: Can you provide some guidance on what procedure codes to use for residential providers?

A203: (See Medicaid Memo dated 5/31/16). Procedure codes and service modifiers can also be located on the DMAS rate sheet available at the following link:

http://www.dmas.virginia.gov/Content_atchs/lrc/My%20Life%20My%20Community%20Rate%20File%201%20Updated%2010_28_2016.pdf

Q204: So on our claims we are just going to enter the modifier for our bed size and we will work with board to put in the bed size into WaMS?

A204: Correct

Q205: For people who have in home service authorizations that are approved through their annual plan year, a change is only need if the modifier is changing, correct?

A205: Correct.

Q206: In WaMS, the provider has 18 lines and when they add another one, it opens a new service box. The old service box is remaining open and has services that remain in pending provider input. Do I need to do something with this?

A206: That is a VAMMIS issue. The PA consultant can probably help you with that.

Q207: We are offering day support services where we are submitting two authorizations as our ratio changes throughout the day. Because this service is seen as a duplicate service, it is not being approved. What can we do?

A207: We didn't have that issue before so it's causing an error in VAMMIS because a provider is not allowed to bill for the same service on the same day. We are currently working with DMAS and the WaMS vendor on a solution.

Q208: My board supports over 500 people but I can only see 128 people. How can I see everyone?

A208: Send an email to Esther Barber. Esther.Barber@dbhds.virginia.gov

Q209: In WaMS when I look at "My list" I cannot pull up a certain individual with everyone else. When I searched I found his name under "My service authorizations without errors." He remains under this list even though he has an approved authorization. It has not affected our ability to bill but is he going to stay in that list? Is this a WaMS error?

A209: Contact the WaMS helpline or send the details to Esther Barber [Ester.barber@dbhds.virginia.gov](mailto:Esther.barber@dbhds.virginia.gov) so she can look at that specific authorization.

Q210: We have provided support for an individual since 10/1. This person was previously under the DD waiver. The private CM is still having issues getting into WaMS and as such the person has not had an authorization initiated. I know we are past the grace period but I wondered if situations like this would allow for a grace period.

A210: The private CM should have a contract with a CSB. The CSB with which the CM has a contract is responsible for managing the authorizations especially if the provider does not have a contract in place. You need to contact the CSB.

Q211: I spoke with CSB who said they would work on getting private CM access. Until this is completed, the CSB can initiate an authorization correct?

A211: Yes

Q212: Who is responsible to enter LOC?

A212: That is a DBHDS function at present; normally it is done when someone comes on to waiver and a new SIS is completed. If there is no SIS in WaMS then a temporary Tier 2 is assigned. The LOC will be updated after the new SIS. Talk to SA to expedite the process.

Q213: If CSB has entered the SA under the wrong address do we have to delete it?

A213: It all should be rolling into the tax id number of the provider.

Q214: When submitting a request through WaMS for Therapeutic Consultation, we are asked to provide the credentials of our director as part of each submission. Is there a way we can be registered as a licensed provider of behavior services instead of submitting our license each time?

A214: SA staff have been advised not to require those when reviewing authorization requests.

Q215: Is there a situation where a provider would offer in home support in someone apartment and bill at the 1:2 or 1:3 ratio? The first time I asked this question, I was told not likely as a provider would bill under supported living for that type of situation.

A215: Supported Living is appropriate in settings that are "provider-operated". "Provider-operated" refers to a location in which the individual receiving support services is 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 by the provider-owner and continuation of supports at that site is dependent upon receiving services from the provider-owner. In-home supports are provided in an individual's own apartment or home.

Q216: When a group home size changes because someone moves in or out, do we have to change the modifiers?

A216: The modifier is for the number of beds the home is licensed for. You don't make any changes if you have an open bed. There would not be a change in the modifier unless you completed a licensing service modification.

Q217: When will WaMS change so that the private case managers will have the option to see each other's caseloads? DD CM organizations have not had that. Will this be accomplished?

A217: This will not be something that will occur due to the limitation of private case managers within the WaMS system. If permissions were broadened, the private cm would have the ability to see all of the individuals the CSB supports. In order to draw some sort of a firewall, the private CM can only see the individuals they support. If someone is out sick, access can be delegated to another CM, but in terms of back and forth and being able to see other CM's caseloads, that is not something that is possible.

Q218: When looking at the reimbursement for group home and beds: If there is an authorization approved and the modifier does not match the current license, do we need to change the modifier now or can it wait until the annual planning year?

A218: As soon as possible after you receive the new licensed capacity, you do need to do a service modification to enter the appropriate modifier. There is an incentive if the licensed capacity going down. If increasing, and there was a DMAS review, that could result in a payback for you.

Q219: We are continuing to have trouble with authorizations not being approved. Who can help us with this?

A219: Contact your DBHDS SA Specialist.

Q220: When do Sponsored Residential providers need to submit a new ISAR?

A220: Please see the **Guidance on Authorizing Sponsored Residential Services released on December 7th**.

Q221: Are customized rates available?

A221: We have not received approval from CMS

Q222: Do you have to have 2 separate authorizations for someone receiving Residential and Community Engagement with same provider agency?

A222: Yes. Each distinct service needs its own Service Authorization.

Q223: After 9/1 will the SC type or scan their plan (part 1-4) into WaMS?

A223: Yes. That will be scanned in. Provider should upload Part V. Only for renewals or annuals or changes not service modifiers.

Q224: Is there a size limit on the files, including the Parts I – V, that will need to be uploaded into WaMS?

A224: No

Q225: Can Part V be an attachment in WaMS?

A225: Yes attachment for now, but future will be using WaMS to do the plan.

Q226: Are quarterlies going to be required to be uploaded in WaMS?

A226: We have not discussed uploading quarterlies at this time.

Q227: Will VIDES be in WaMS?

A227: Yes

Q228: Can you print the VIDES from WaMS.

A228: Yes

Q229. What “formula” is being used that is considered “more accurate” in determining SIS levels?

A229: Virginia scoring uses two numbers:

a. One number is very similar to the score obtained using the basic A + B + E formula; this method rounds A, B and E individually to whole numbers.

b. The second number calculates A, B and E without rounding.

A level and tier is calculated using each of these numbers. The two levels and tiers are compared and the higher one is assigned as the final level and tier.

This method was chosen, because the basic A + B + E formula, in rare cases, scores persons with higher need, lower, and persons with lower need higher, due to the standard scores being rounded to whole numbers.

Virginia scoring will not result in a decreased level from the number defined in “a.” above. This is because Virginia assigns whichever level and tier is higher per the explanation above. Because the “basic A + B + E formula” calculated by a provider is not mathematically precise, this number should not be used for comparison.

Q230: I had a service pended by PA who said I have to end the previous Service Authorization Request (SAR). Can we not modify an SAR?

A230: You can modify a SA request. DBHDS has contracted with two trainers who will provide training and support with WaMS. Online training is available and the WaMS helpline can assist or direct you to the correct staff person.

Q231: When submitting an SAR, SA said they need a schedule. Is that a requirement now?

A231: Yes. The schedule is part of the providers Plan for Supports. At this time, the only exceptions are Service Facilitators or agencies utilizing the DMAS 97 A/B or nurses utilizing the CMS 485. In these situations, the DBHDS Personal Preferences Tool is required to meet the person-centered plan requirements of the DD waivers.

Q232: CM requesting behavior plans for anyone who receives a score of 2 on the SIS, can this be done by the residential or is a formal plan needed?

A232: A formal plan is not needed according to regulations, but if billing for the Exceptional Supports Rate it would be necessary.

Q233: Which service location should we choose in WaMS?

A233: Depends on the physical service location. Choose the provider and the service tied to that provider.

Q234: We have services that were imported incorrectly such as in-home instead of SR? Who do we contact?

A234: Send info to Esther Barber and copy Cheri and they will correct.

Q235: What do we do when an external private provider does not terminate a service and continues to have an approved service authorization, which prevents adding another authorization?

A235: Have you reached out to the provider and ask them to end the authorization? The provider has to end the service. If necessary, the SC has the ability to assign the service to the appropriate provider.

Q236: When completing Assistive Technology and Environmental Modification Requests in WaMS, will the SC need to log out and back in as a provider to complete the entry?

A236: You still have to go in as the role you are completing. With the dual role you will have to assign those roles to the appropriate staff. SCs will need to have the provider ISP approval role. If you need assistance call the WaMs help desk.

Q237: Do EM and AT providers have access to WaMS?

A237: They can have access, they still need to register through WaMS.

Q238: In WaMS I'm finding that I do not have a revise button or an add button. Do I need to call the WaMS helpline?

A238: Yes that has to do with the software.

Q239: Several of our service locations are not being shown in the WaMS system. Do we need to submit another application?

A239: No, but we do need to find out why they are not listed.

Q240: Could it have to do with the address? We have three locations but only one address is listed.

A240: If you have an issue with the address then we get a provider file from VAMMIS. Contact the provider helpline and update info in VAMMIS so it will come over the provider file.

Q241: We (residential provider) have two MPI numbers and when WaMS was first established we had to set up two different logins. Should we be concerned that all of the individuals are under one log in?

A241: No. Because so many organizations had multiple MPI numbers WaMS attached all NPI numbers to the one tax ID number.

Q242: We have an individual that was in IDOLS and is missing in WaMS.

A242: The SC has to initiate this in WaMS to allow for you to put her in. You should see the alert if the SC put the information in.

Q243: For Day Support Hours we initially put in the max of 66 hours and it was rejected. We were going to use the hours as needed for flexibility. PA rejected the SA, saying we can only submit 10% of time above the time really needed. Is this going to be looked at or is this final?

A243: Per the 12/19/16 Medicaid memo regarding day services: A provider may request additional hours to their service authorization request for the combination of these services.

- In no circumstances can the additional hours total more than 66 hours per week;
- The request should include the reason for the additional hours;
- The provider must state that they understand that only services delivered will be billed;
- Attendance log and provider documentation must be maintained to verify service deliver.

Q244: GH Providers now bill 344 days per year. For the individuals that do not go anywhere on the 21 days, how do we bill for these days?

A244: The amount you are reimbursed is inflated to equal the amount you would be paid for the 365 days. Review the final rate models document to understand how the rates were calculated:

http://www.dbhds.virginia.gov/library/developmental%20services/va%20dbhds%20ratemodels_final_rev1_2016_03-22.pdf

Q245: For Skilled Nursing prior to the Redesign we usually provided 2 hours per location. Which service do we provide now and how do we bill?

A245: Private duty is a larger duration /shift. Skilled Nursing is a few hours to the person, a smaller block of time. You may need to submit a new authorization for the correct service.

Q246: The same reports that were in IDOLS we need in WaMS. Is there a committee working on this?

A246: Phase III will add reports to WaMS. There will be several reports available prior to Phase III. We used the old forms in IDOLS to develop the reports in WaMS.

Q247: Are there any fixes for someone who is having problems daily getting into WaMS?

A247: Try clearing out your history.

Q248: Once everything is in WaMS, what is the turnaround time?

A248: Typically 10 days but PA staff are very busy so may be a little longer at this point due to excessive requests. Pends also affect the 10 day turnaround time.

Billing

Q249: When completing Assistive Technology and Environmental Modification Requests in WaMS, will the SC need to log out and back in as a provider to complete the entry?

A249: You still have to go in as the role you are completing. With the dual role you will have to assign those roles to the appropriate staff, SCs will need to have the provider ISP approval role. If you need assistance call the WaMs help desk.

Q250: Why does it take so long to get approval for environmental modifications?

A250: It depends on what the SC writes as justification. Sometimes there may be a need for more information. DBHDS has hired additional SA staff to assist and are working on developing training for SCs on the processes of justification.

Q251: When are billing units rounded daily, weekly or once prior to submitting the bill?

A251: It is rounded once a month regardless of number of billing submissions each month.

Q252: How do support rations affect billing?

A252: Services requiring rations should not be billed unless the appropriate ratios are provided.

Q253: Will DMAS be offering training on billing?

A253: Billing training is available on the DMAS website at the following link:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderTrainingLibrary>

Q254: If I go to rebill because of change in tier do I use the code under correcting charges?

A254: Send an email to Ann Bevan Ann.bevan@dmas.virginia.gov and she will send it to the DMAS contractor to get an answer.

Q255: Can day support services continue to bill high intensity center-based day supports until their annual planning year?

A255: Yes. Please refer to the Medicaid Memo dated 9/1/16.

Individuals authorized for Day Support services will remain authorized for that service and providers will continue to bill according to the current "block" unit structure until such time as the provider submits service authorization requests to move the individual to Group Day Services (or another service), which is billed in hourly units. Providers may opt to do this at one time for all individuals they support or as individuals' annual ISPs are updated. All authorizations must be converted to the new group day service no later than the end of the individual's current ISP.

Q256: Billing under per diem system – Is there a minimum numbers of hours required during a day for an individual to be counted as present? Can you bill for the whole day if the individual is only there for 15 minutes?

A256: There are no current waiver regulations on this. No lower limit has been set, but we want to ensure this is not being abused. Future discussion will likely be had regarding this issue.

Q257: Billing – Do we round up to use weekly overage?

A257: If billing is weekly – add up fractions to whole number – same rules as in the EDCD Manual Ch. V – this will be clear in the new manual.

Q258: Where can we find the updated rates?

A258: Rates are located on the DMAS website

http://www.dmas.virginia.gov/Content_attachments/My%20Life%20My%20Community%20Rate%20File%201%20Updated%2010_28_2016.pdf

Q259: Can you clarify how the billing will work for day support once it is transferred into WaMS?

A259: For individuals who have an authorization, the current ISAR will be loaded into WaMS with the old rates billed as a block/unit per individual per program. Providers will need to submit new service authorizations to convert from block to hourly billing when they choose to, but no later than the start of the annual ISP year. If other day services are added, new service authorizations will be needed to adjust the hours for both services.

Q260: Private duty and skilled nursing. What changes do we need to make to ensure we can bill for private duty? What is the difference?

A260: The difference is that PD is longer term nursing provided throughout a day as opposed to an activity for an hour or two. Ensure your DMAS Provider Participation Agreement is in good standing. Fill out the Provider Participation for PD, which will be available as soon as we have approval from CMS. Open a new service for that person. A Provider Choice form will also need to be completed by the SC.

Q261: What is the reimbursement for DD screenings?

A261: Reimbursements completed by the CSB can be billed at \$300 for the rest of state and \$350 for NOVA. To be reimbursed, the CSB will send the information to DBHDS and they will send a report to DMAS who will then reimburse the CSB.

Q262: For programs that are non-center based, are we allowed to bill starting when we pick the person up?

A262: Community engagement and coaching starts at the time the individual gets on the van to go to the activity. Also, there is a 10% allotment for Community Engagement where they are allowed to be in the center face to face with a staff person to set their schedule.

Q263: We (day support provider) are going to be doing interactive services where an individual actively interacts with persons without disabilities. If they go to a park and are not actively interacting with someone, can we still bill?

A263: The language used in the service description refers to spending time in the community at naturally occurring times to interact with individuals that would naturally be in that setting. The purpose of the community engagement and community coaching programs are to develop relationships. Time in the community not focused on developing relationships can always be billed as group day.

Q264: What will the hourly billing look like for group day? Will it be the sum of the hours, or account hour by hour for everything people are doing?

A264: That depends on the services you are offering. If you are doing day services, you will need total hours for billing purposes, and still need a schedule of activities and what people are doing for documentation.

Q265: If we are planning to provide community supports and day supports, can we just bill under the new services after 9/1?

A265: No. You have to do a new provider participation agreement with DMAS and be approved to provide that service through an authorization in WaMS. Remember this is a new service so you will need to do a separate Part V as well.

Q266: This question came from the ARC Conference. Historically we have group homes and we understand the daily rate and with in-home we only have 1:1 now, but will have 1:2 and 1:3. Are there any situations where 2 or 3 people living in the same house where 1:3 in-home would be an appropriate service as opposed to group home?

A266: Likely not. Generally that service would be billed under group home or supported living, however, we have recently had a related question we submitted to Burns and we may need to explore that more with some providers. Providers operating group homes should not be billing the in-home rate nor should apartments operated by a provider that should be supported living.

Q267: For therapeutic consultation, we previously billed in units. Since it is now hours, will those authorizations need to be resubmitted?

A267: Therapeutic Consultation has always billed hourly but as there are different reimbursement amounts and codes, you will need to initiate a new authorization request in WaMS.

Q268: For months that have 31 days, can we bill for 31 days for a group home?

A268: Because the authorization is for 344, you can bill for the total number of days each month while not exceeding a total of 344 days in a given ISP year.

Q269: For services where the rate is dependent on the number of people in the group, how do we bill when the size of the group changes due to callouts, change in work schedule, etc.

A269: The ratio is set at the time of authorization and would not change again until another authorization is submitted.

Q270: If a BCBA is working in a group home with 2 people receiving Therapeutic Consultation and the BCBA is doing observation and data gathering for an hour, (watching interactions among the people in the house), is that 2 hours of billing?

A270: Only bill the total of one hour. The time should be split between the 2 individuals.

Q271: H2022 exceptional rate clients. The U1 modifier is listed but it is not paying it at this time?

A271: Group Homes no longer receive the ESR. Services are reimbursed according to their tier and level. If you are billing the H2022 there is no ESR. A new process intended to replace the exceptional supports rate will be submitted to CMS for approval. Implementation of the new process cannot begin until approval is obtained from CMS. This process will be the method by which providers can request increased financial support for those individuals with medical/behavioral support needs that

cannot be met within the current rate structure. Once approved, guidance will be provided on the parameters of accessing reimbursement under the new process.

Q272: How do we get the U1 removed?

A272: You can call Sam Pinero or send Tracy Harris the ICM number and the denial reason.

Q273: For day services, if an individual is leaving services does that mean the old provider does not bill the last day of services?

A273: This needs to be negotiated between the two providers.

Q274: Is the rounding policy operational going forward? Does it include all waiver services including day support?

A274: Yes and yes.

Q275: Clarification needed on rounding memo dated Sept 1; can you bill throughout the month but can only round on the monthly total?

A275: Yes. You can only round at the end of the month. Rounding each week will inflate your time. If billing weekly; bill the exact hours and if you have an overage hold to end of month and then bill those.

Q276: We accidentally billed under an incorrect authorization. We ended the authorization and corrected it but how do we show this was caught and corrected?

A276: Keep any documentation that supported what you did and all correspondence and remittances that went with it.

SIS

Update: The SIS tiers have been updated in WaMS. WaMS is not able to automatically update this in VAMMIS. This will require SA staff to manually enter this information into VAMMIS and as such will take a couple of weeks. You can check in WaMS to see if a particular tier has been updated or changed.

Q277: When looking at the old SIS formulas we were given, we are coming up with a number of people who would have qualified for Tier 4 that are not qualifying now. It looks like the cutoff previously was 7 but now is 9. Will scores be reevaluated?

A277: Scoring of SIS-A[®] is consistent with scoring of SIS[®] so here is no need for old scores to be reevaluated. If you have a concern, please reach out to your RSS.

Q278: I heard the SIS scores and tiers are being reevaluated, is that correct?

A278: No. The scores and tiers are not being reevaluated. There was a question as to whether there were any gaps when the state moved from one version of the SIS to the SIS-A. Because scoring was developed for consistency between SIS and SIS-A there are no “gaps” in scoring.

Q279: Am I correct in understanding that some people without a new SIS were assigned a level and tier based on the old SIS?

A279: Yes.

Q280: What would we do if a SIS is not done when the WaMS system goes live?

A280: Ascend has identified those that are in need of SIS assessments and are working to complete them.

For individuals who have never had a SIS, the individual will be assigned to tier two. Should the SIS be completed and the person is assigned to tier one, we have been informed by DMAS that the provider will be held harmless.

For Individuals with an old SIS, this will be used until a new SIS is completed. The provider can adjust their billing once the tier is known.

Q281: Once a new SIS is completed, does the Tier change on the 1st of the next month

A281: No. Tier changes occur based either on the person's assignment to active enrollment status in WaMS or the SIS interview date. Call your SA or Regional Support Specialist to find out the date the tier will apply.

Q282: We (private provider) received a spreadsheet from the CSB of SIS scores and corresponding levels/tiers, however, there are about 15 individuals we support not listed. What should we do?

A282: Providers can now view this information in WaMS.

Q283: If a SIS has been completed and t we have not received the results, how will we know how to bill?

A283: The level and tier should be assigned in WaMS.

Q284: We noticed a data entry issue when the tier is not matching what we presumed it to be. How do we correct that?

A284: CM will have access to the levels and tiers in WaMS as determined by the latest SIS. Mathematically, there are times that the number in the system is different than the score you found manually.

Q285: I've heard the number will always be higher. Is that correct?

A285: Because it deals with more than whole numbers it allows for a more exact number. Based on two calculations performed by DBHDS for each SIS, the higher level and tier between the two is assigned.

Q286: What Tier will be assigned to someone that has not had a SIS yet?

A286: Those who have not had a SIS will be placed into Level 2 -> Tier 2. This will only apply to someone who utilizes services that are tier-based. The provider will bill Tier 2 until the SIS is completed. If an individual is receives a rating of a level 1, the provider will be held harmless up to the SIS interview date. If individual's support needs based on the SIS meet Tier 3 or 4, they can adjust their billing and backdate to the day supports started.

Q287: Then they only have access to Level 2 services?

A287: It's just a matter of reimbursement. It doesn't change the services the individual has access too.

Q288: I understand that the SIS establishes level of need and is not appealable. Why?

A288: The interviewer's failure to follow one or several of the VA SIS Standard Operating Procedures (SOPs) is appealable. . The SIS scores and levels and tiers are not appealable. There are many look backs and verification processes in place that assure assessments are accurately rated.

Q289: How is this different than IDEA parents who appeal and win on procedural matters, not content?

A289: The procedural processes are appealable.

Q290: There is less money available to providers who support people with lower levels. Does this provide an incentive for a lower score?

A290: Quality and accuracy of SIS assessments is of paramount importance. SIS interviewers receive intensive and rigorous training before completing the SIS. Interviewers are audited every 6 months, on a rotating basis by AAIDD and Ascend. Every SIS assessment is individually reviewed for quality completion at two levels by Ascend before it is made available for distribution. In addition, DBHDS conducts reviews for accuracy as well.

Q291: Can we revisit the appeal issue with appealing the level or tier?

A291: No. If there are concerns, family members are welcome to call Joan Bender at DBHDS.