Preface

Background

The Department of Behavioral Health and Developmental Services (DBHDS) has a long history of offering supplemental funding to providers supporting individuals whose support needs fall outside of standard Waiver funding and who are identified as outliers to the standard Waiver structure. Multiple programs have supported this effort to include 'bridge funding,' 'transitional funding' and the 'exceptional support rate.'

Over time, DBHDS has worked with community partners to define criteria that helps to identify individuals whose support needs fall outside of the services offered in a standard Waiver program. As a long-term solution to identified funding gaps that exist amongst this population, DBHDS, in partnership with DMAS created the customized rate program.

Effective June 1, 2017 the Center for Medicare and Medicaid Services (CMS) approved a Waiver amendment allowing DBHDS licensed providers to apply for a customized rate for individuals who meet qualifying criteria. 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 herein.

Customized rates are funded by the Waiver directly. This Waiver amendment allows DBHDS to approve a modified rate which replaces the standard rate for the individual's assigned level and tier. Upon approval, providers are required to submit a service authorization request for the specified service following all service authorization guidelines.

Forums

DBHDS will hold an annual provider forum which will be a time for providers to discuss the customized rate process, receive training and provide feedback. It will also be a time for DBHDS to discuss the overarching goals of the program and any possible upcoming changes. Additional forums throughout the year will be held as necessary.

Additionally, DBHDS a DMAS will meet annually to review the programs goals, guidelines and business rules. Communication regarding these forums, outcomes or training opportunities will be disseminated through listserv and/or the DHBDS website: www.dbhds.virginia.gov

Guide Purpose

The purpose of the Guide to Customized Rates is to provide practical and specific information to supplement the Waiver Regulations. Where possible, the Guide seeks to illustrate evolving best practices when submitting an application and to clarify program rules and stipulations.

- Provides a one stop shop for all information related to customized rates.
- Serves as a handbook regarding how to apply for a customized rate and outlines the process and criteria for approval.
- Clarifies and expands on the roles, responsibilities, and expectations of providers.

Guide Preparations & Updates

The original ***Guide***, published in July of 2007, was the result of cooperative efforts between DBHDS and DMAS who meet annually to discuss the program and the content of the provider Guide. The Guide is created collaboratively by The ***Office of Administrative and Community Operations*** of the Division of Developmental Services and ***DMAS*** with input from a variety of sources. In 2021, DMAS began receiving recommendations and comments from community providers through the town hall public comment process. Hereafter, any changes to the Guide that have the potential to effect the overall program will be posted to the town hall for public comment. Every effort has been made to ensure content consistency in the customized rate provider Guide.

Additional Resources

Providers can receive help and support with navigating the customized rate application in WaMS by locating the customized rate WaMS user guide located in the 'help' section of WaMS. This guide provides step by step instructions regarding WaMS navigation relating to application submission, uploading supplemental data and contingent approvals.

Guide Content

Part 1: Definitions-provides general definitions for customized rate acronyms, staff roles and other important definitions that are reflected in the guide.
Part 2: Basic Information-defines customized rate funding, qualifying services and approval criteria.

Part 3: Eligibility- Provides a list of eligible Waivers and services and defines provider eligibility.
Part 4: Determinations-Defines the process by which DBHDS processes applications and makes determinations to include provider responsibility when submitting an application.
Part 5: Specialized staffing- Defines specialized staffing and lists the qualifying criteria that staff must meet in order to become eligible to include the three approval levels and a list of documentation requirements.
Part 6: Programmatic Oversight- Defines programmatic oversight and lists the qualifying criteria that staff must meet in order to become eligible to include the three approval levels and a list of documentation requirements. Also includes a list of approved tasks and responsibilities that staff must perform in order to meet approval criteria and a list of approved human services related degrees.
Part 7: Rate Information- Provides a description of fixed vs. flexible rates, provide rate specific information and methodology.
Part 8: Application and Forms- Details how to apply for a customized rate, where to access the application and forms and details the process of application review to include committee review.
Part-9: Supporting Documentation- Lists the supporting documentation necessary when submitting an application.
Part-10: Approvals- Describes approval criteria and explains how providers will be notified of an approval. Provides information related to documentation requirements for approvals and annual review requirements.
Part-11: Service Authorization- Provides basic service authorization information relative to customized rate funding, lists service authorization codes and information specific to billing an approved customized rate.
Part-12: Denials- Provides information related to denial criteria. Informs on appeal rights and non-discrimination.
Part-13: Getting Help- Provides a list of email and phone contacts relating to WaMS support and customized rate questions. Lists frequently asked questions.

Customized Rate Provider Guide

Effective January 1, 2022

Part I: Definitions

1.1-GENERAL DEFINITIONS

a) Customized Rate (CR) - A Medicaid waiver rate approved by a committee of experts for individuals with complex medical and/or behavioral support needs whose needs fall outside the standard rate structure for their assigned level and tier.

b) Service Location-The location of the service which is provided falling into two outlined regions:
- ROS=Rest of State
- NOVA=Northern Virginia

c) Supports Intensity Scale (SIS©) - The tool identified to measure the individual's support needs resulting in a reimbursement Tier as follows:
- Level 1= Tier 1
- Level 2= Tier 2
- Levels 3-4= Tier 3
- Levels 5-7= Tier 4

d) Individual Support Plan (ISP) – A written document that describes the type of the supports, activities, and resources that an individual agrees are important to or for achieving and maintaining personal outcomes.

e) Waiver Information Management System (WaMS)- Virginia Waiver Management System (WaMS) is the data management system that manages the DD waivers; houses a record of the Individualized Service Plan (ISP); is the entry point to request Service Authorization for DD waiver services; and acts as a conduit for communication between Providers, Support Coordinators, and DBHDS.

1.2-ROLE DEFINITIONS

a) Customized Rate Consultant (CRc) - Designated customized rate staff that provides support to providers with pre-submission technical support, direct on-site support and conducts pre-review assessments to confirm that providers have sufficient evidence to justify a customized rate prior to committee review.

b) Customized Rate Processor (CR Processor) - Designated customized rate staff that is primarily responsible for processing incoming customized rate applications to ensure proper documentation is available upon committee review and for corresponding with providers regarding application status.

c) Customized Rate Administrator (CR Administrator) - Designated customized rate staff that is primarily responsible for overseeing the customized rate process.

d) Customized Rate Review Committee (CRRC) - A committee of experts who make determinations on applications submitted for a customized rate.

1.3-FORM DEFINITIONS

a) NOA- The customized rate Notice of Action Form (NOA) which documents and notifies the provider/applicant of the customized rate review committee's decision to approve or deny.

b) NOP- The customized rate Notice of Pre-Review (NOP) which documents and notifies providers who are requesting pre-review of a customized rate prior to accepting an individual into services and documents the customized rate review committee's determination.

c) FORM 011-Request for pre-review. This form is completed by providers who are requesting pre-review of a customized rate prior to accepting an individual into services.

d) Form SF-20- An excel document which is required for all customized rate applicants and documents the providers program budget, staff schedule and credentials. This document can be located at: **https://www.dbhds.virginia.gov/developmental-services/waiver-services**

e) WaMS Customized Rate User Guide- A navigation guide that providers can refer to for help with navigating the customized rate application in WaMS located within the 'help' section of WaMS.

1.4-SUPPORT/RATE DEFINITIONS

a) 1:1 Support- One staff assigned to the individual served who remains within arms distance at all times and whose sole responsibility is to support the individual based on their exceptional medical and/or behavioral support needs during the time 1:1 supports are approved.
b) 2:1 support- Two staff assigned to the individual served who remain within arms distance at all times and whose sole responsibility is to support the individual based on their exceptional medical and/or behavioral support needs during the time that 2:1 supports are approved.
c) Specialized Staffing- Direct support provided by professionals who have a higher level of expertise which is required to ensure proper supports is given based on the individual's exceptional support need.
d) Programmatic Oversight- Oversight that is associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individual's 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 Disability Professionals and whose expertise is not available through contracting for professionals which are Medicaid waiver vendors.
e) Fixed rate- A type of customized rate approval that is pre-determined based on input from Health Management Associates, Inc. and is approved based on demonstrated need for either a higher level of staff credentialing or a higher staff to individual ratio of supports, or both being required. Fixed rates require additional approval from service authorization staff who must determine the total hours approved based on the approved customized rate.
f) Flexible rate- A type of customized rate approval 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. The total supports combined replace the standard rate for the specified service without further service authorization review**.**

Part 2: Basic Information

Effective June 1, 2017 the Center for Medicare and Medicaid Services (CMS) approved a waiver amendment allowing providers to apply for a customized rate for individuals who meet certain criteria as described herein. Providers are eligible to apply for a customized rate under the current Waiver system by accessing the customized rate application located in WaMS. 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 herein.

2.1-APPROVAL CRITERIA

a) 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.
   - and/or
   - The individual requires 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them.

2.2-QUALIFYING SERVICES

a) 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.
   - Higher credentialed direct support staff (Specialized Staffing) to ensure proper supports is given. This means that direct support professionals are required to have a higher level of expertise in order to provide specialized supports to the individual.
   - Increased programmatic costs associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individual's 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).

Part 3: Eligibility

Any provider supporting an individual on the Family & Individual Supports Waiver or Community Living Waiver are eligible to apply for a customized rate regardless of the individual's assessed SIS© score. Providers supporting an individual assessed to have support needs at SIS© levels 1-5 must be verified by a Customized Rate Consultant (CRc) prior to review by the Customized Rate Review Committee (CRRC).

3.1-ELIGIBLE WAIVERS & SERVICES

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

3.2-PROVIDER ELIGIBILITY CRITERIA

a) Providers providing supports for an individual due to the individual's behavioral support needs shall consult with a qualified behavioral specialist. This qualified behavioral specialist shall develop a behavior plan based upon the individual's needs and train the provider's staff in its implementation. Both the behavior plan and staff receipt of training shall be documented in the provider record.

b) Providers shall have training policies and procedures in place and demonstrate that staff has received appropriate training including, but not limited to, positive support strategies, in order to support an individual with mental illness or behavioral challenges, or both.

c) Providers shall have on file a crisis stabilization plan for all qualifying individuals with complex behavioral needs. This plan shall include the direct interventions necessary to mitigate risk of emergency psychiatric hospitalizations or institutional placement and should include when appropriate, admission to crisis response services that are provided in the Commonwealth.

d) Providers should be able to evidence their ability to meet the individual's exceptional support needs through documentation of all that apply; staff training, employment of or contract with an RN, involvement of a behavioral or psychological consultant or crisis team.

e) All staff who will be supporting a qualifying individual shall receive individual-specific training regarding the individual's medical condition or conditions, medications, risk factors, safety practices, procedures that staff are permitted to perform under nurse delegation, and any other training deemed necessary to enable the individual to be safely supported in the community. The provider shall arrange for the training to be provided by qualified professionals and document the training in the provider's record.

f) Providers should be able to demonstrate that they can meet the support needs of the qualifying individual through employment of qualified staff trained to provide the extensive supports required by the individual based on their exceptional support needs. Providers may qualify for customized rate reimbursement, only when the provider's staff directly performs the support activities required by the individual for whom a customized rate is requested.

3.3-ELIGIBLE SUPPORTS

a) 1:1 Support- defined as one staff assigned to the individual served who remains within line of sight at all times and whose sole responsibility is to support the individual based on their exceptional medical and/or behavioral support needs during the time that 1:1 supports are approved.
b) 2:1 support- defined as two staff assigned to the individual served who remain within line of sight at all times and whose sole responsibility is to support the individual based on their exceptional medical and/or behavioral support needs during the time that 2:1 supports are approved.
c) Specialized Staffing- defined as direct support provided by professionals who have a higher level of expertise which is required to ensure proper supports is given based on the individual's exceptional support need (Refer to Section 5).
d) Programmatic Oversight- defined as oversight that is associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individual's 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 Disability Professionals and whose expertise is not available through contracting for professionals which are Medicaid waiver vendors (Refer to Section 6).
e) Eligible supports vary by service. See section 7.2 {Rate Methodology}.

Part 4: Determinations

It is the provider's responsibility to evidence through the customized rate application and through submission of supporting documentation that the applicant meets qualifying criteria. This includes clearly articulating the Individual's support needs within the customized rate application, providing supplemental documentation that indicates that the individual's support needs fall outside of what is provided for their assigned level/tier funding, by attaching all requested supporting documentation and following all submission guidelines outlined herein.

a) Once an application is received in WaMS, the submitted information is reviewed by a customized rate processor to ensure all essential information has been included. If it is determined by the processor that additional information is required, the provider will receive a form note in WaMS alerting them of the need for additional information.
b) Form Notes are used as a communication modality between DBDHS and the provider regarding the customized rate request and is located within the application in WaMS. It is the provider's responsibility to check WaMS frequently and to respond to requests made by DBHDS in the Form Notes section of the application. Providers who have applications that are inactive in WaMS for longer than 30 days will be notified via form notes that the application will be rejected. Following a 10 day grace period, DBHDS will reject the application. Rejected applications will not have appeal rights.

4.1-VERIFICATION (LEVEL'S 1-5)

a) Applicants whose SIS© level falls within levels 1-5 must be verified by a Customized Rate Consultant (CRc) prior to review by the Customized Rate Review Committee (CRRC).
b) Once an application is reviewed by the processor and it is determined that all necessary supporting documentation has been included with the application, the application is forwarded to the CRc who will contact the provider to conduct an assessment which will be conducted either on site or by phone.
c) During the assessment the CRc will validate the information within the application, ensure that all front line supports have been explored and/or accessed and review supporting documentation related to the customized rate application.
d) Following the assessment, the CRc will make a recommendation based on his/her findings to (1) move the application to the CRRC for review or (2) deny the 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.
e) If the CRc decides to deny the application, a Notice of Action (NOA) letter will be emailed to the provider with an explanation of the denial. The NOA will be emailed to the staff member listed as the point of contact on the customized rate application.
f) Regardless of the individual's SIS© level, the CRc is available to assist providers with verification and/or technical support prior to submitting an application.
g) Providers submitting an application for an individual falling in SIS© levels 6-7 may at the discretion of the CRRC be asked to participate in a pre-assessment conducted by the CRc prior to committee review.

4.2-COMMITTEE REVIEW

Once an application has been reviewed and determined that all necessary supporting documentation has been included with the application, and if applicable, reviewed by the CRc, the application is forwarded to the CRRC. The CRRC is a team of experts who provide input as it relates to medical, behavioral, integrated supports, service authorization, and regional support services. The CRRC reviews all applicants regardless of SIS© level (unless denied by the CRC [level's 1-5]) and makes the determination as to if a customized rate is approved.

Part 5: Specialized Staffing

Specialized staffing is defined as direct support provided by professionals who have a higher level of expertise which is required to ensure proper supports is given based on the individual's exceptional support need. Providers are expected to provide within the application, a written description of the staff's abilities to meet the needs of a qualifying individual and the training received related to such needs. Providers can request specialized staffing for any portion of their 1:1 or 2:1 support hours. To qualify for 'Specialized Staffing' providers must meet ALL criteria in at least ONE of the listed approval levels (1-3).

5.1-SPECIALIZED STAFFING-APPROVAL LEVELS

- **Approval Level 1**
  - A college degree
  - Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service
  - Major studied must meet the intent of a Human Services degree {see list of Human Services and Related Fields Approved Degrees in section 6.3}
  - Support provided must be directly related to the individual's exceptional support needs
  - *Example: Associates in Human Services*
- **Approval Level 2**
  - Specialized licensing
  - Support provided must be directly related to the individual's exceptional support needs
  - *Example: Certified Nursing Assistant*
- **Approval Level 3**
  - Specialized training which is not typical of a standard Direct Support Professional
  - At least 5 years working with individuals identified as part of the target population
  - Support provided must be directly related to the individual's exceptional support needs
  - *Example: Medication Aide trained and 5 years' experience working with medically fragile individuals*

5.2-SPECIALIZED STAFFING: DOCUMENTATION REQUIREMENTS

a) Providers are required to submit evidence that staff meet the outlined criteria by submitting official transcripts, credentials, resume, or any other documents which indicate the level of combined education, training and experience.
b) Providers may be asked to provide documentation related to the staff providing specialized support such as record of payroll or provide a W-2.
c) Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service.

Part 6: Programmatic Oversight

Programmatic Oversight is defined as oversight that is associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individual's 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 Disability Professionals and whose expertise is not available through contracting for professionals which are Medicaid waiver vendors. Providers are expected to provide within the application a written description of the staff's abilities to perform programmatic oversight based on the qualifying individual's exceptional support needs and the training, education and experience received related to such needs.

6.1-PROGRAM OVERSIGHT-APPROVAL LEVELS

To qualify for 'Program Oversight' providers must meet ALL criteria in at least ONE of the listed approval levels.

- **Approval Level 1**

- Master's level degree
- Qualifying degrees must have been awarded from among the schools listed on the U.S. Department of Education College Accreditation database (https://ope.ed.gov/dapip)
- Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service
- Major studied must meet the intent of a Human Services degree {see list of Human Services and related fields approved degrees in section 6.3}
- Support provided must be directly related to the individual's exceptional support need
- Programmatic staff must be responsible for at least three or more of the program oversight approved responsibilities {See list of approved tasks and responsibilities}
- *Example: Master's degree in in Behavioral Science*

- **Approval Level 2**
  - Bachelor's level degree
  - Licensure in their specific area of expertise
  - Qualifying degrees must have been awarded from among the schools listed on the U.S. Department of Education College Accreditation database (https://ope.ed.gov/dapip)
  - Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service
  - Major studied must meet the intent of a Human Services degree {see list of Human Services and related fields approved degrees in section 6.3}
  - Support provided must be directly related to the individual's exceptional support need
  - Programmatic staff must be responsible for at least three or more of the program oversight approved responsibilities {See list of approved tasks and responsibilities}
  - *Example: Bachelor of Science in Nursing (BSN) and Registered Nursing license*
- **Approval Level 3**
  - Bachelor's level degree
  - Additional training related to the scope of responsibilities as identified within the program oversight approved tasks/responsibilities {See list of approved tasks and responsibilities}
  - At least 5 years working with individuals identified as part of the target population
  - Qualifying degrees must have been awarded from among the schools listed on the U.S. Department of Education College Accreditation database (https://ope.ed.gov/dapip)
  - Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service
  - Major studied must meet the intent of a Human Services degree {see list of Human Services and related fields approved degrees in section 6.3}
  - Support provided must be directly related to the individual's exceptional support need
  - Programmatic staff must be responsible for at least three or more of the program oversight approved responsibilities {See list of approved tasks and responsibilities}
  - *Example: Bachelor's degree in Human Services, and training certification in Autism Spectrum Disorder and 5 years of experience working with individuals with Autism*

6.2-PROGRAMMATIC STAFFING: DOCUMENTATION REQUIREMENTS

a) Providers are required to submit evidence that staff meet the outlined criteria by submitting official transcripts, credentials, resume's, or any other documents which indicate the level of combined education, training and experience.
b) Providers may be asked to provide documentation related to the staff providing programmatic support and oversight such as record of payroll or a W2.
c) Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service.

6.3-PROGRAM OVERSIGHT, APPROVED TASKS/RESPONSIBILITIES

a) Oversight which constitutes the practice of licensed professional services (e.g. nursing, behavior analysis) must be overseen by appropriately licensed/credentialed professionals performing duties within their scope of practice as indicated through their professional licensing/credentialing board. Programmatic staff, as a part of their core responsibilities must perform 3 or more of the following approved tasks and responsibilities to qualify:

b) Training to direct support staff (especially as it relates to changes in care plan), which is evidence-based and/or evidence driven requiring adherence to support protocols.
c) Development of protocols and implementation of the processes that drive effective, safe, evidence-driven interventions/plans of care which result in outcomes that improve the daily life of the individual with high needs.
d) Oversight of medical or behavioral data to assure proper implementation of protocols, including changing the protocols as needed as an individual navigates his or her environment successfully, to achieve maintenance at a less intense level of staffing and resources, which results in a higher quality of engaged life with the community and family.
e) Serve as a liaison and provide expert opinion related to hospitalization and/or severe crisis interventions to ensure that protocols are maintained and/or amended as needed to reduce or prevent future hospitalizations, whether medical or behavioral; and in cases with individuals with a history of or at risk of law enforcement involvement, ensure that officers and others are advised, trained or connected such that risk of legal system involvement is avoided due to failure to provide adequate supports.
f) Oversee overall medical or behavioral operations to ensure that they are not only effective, but coordinated with external providers, Community Services Boards (CSBs), emergency services and that protocols are clear regarding when and how to involve external providers.
g) Oversee resident and/or program participant care to ensure all aspects of services which are prescribed and/or recommended by service area experts are delivered according to the individual's identified financial, medical, behavioral, social, and emotional support need.
h) Coordinate and/or facilitate consumer related meetings and appointments to include medical appointments, behavioral health, psychiatric services, and individual service plan meetings.
i) Overall management of program operations to include implementing agency policies and procedures, physical site management, financial procedures and budget, and compliance with human rights and licensing regulations.
j) Monitor staff performance, conduct staff evaluations, develop disciplinary plans of actions, facilitate new hire processes including advertising and recruitment and develop staff schedules to ensure staff that are qualified to support the unique needs of all consumers are employed.
k) Act as the primary point of contact providing individual and program specific information to stakeholders such as families, guardians, state representatives, and community services boards and make critical decisions related to overall program operations.
l) Explores, requests and coordinates the use of supplemental funds and supports to ensure that all resources, to include natural resources and state/local funding are maximized. This might include facilitation of Waiver services, accessing REACH or other crisis services, managing customized rate funding requests or applying for local funding.

6.4: HUMAN SERVICES AND RELATED FIELDS, APPROVED DEGREES

- Art Therapy
- Behavioral Sciences
- Child Development
- Child and Family Studies/Services
- Cognitive Sciences
- Community Mental Health
- Counseling (MH, Vocational, Pastoral, etc.)
- Counselor Education
- Early Childhood Development
- Education (with a focus in psychology and/or special education)
- Educational Psychology
- Family Development/Relations
- Gerontology
- Health and Human Services
- Human Development
- Human Services
- Marriage and Family Therapy
- Music Therapy

- Nursing
- Pharmacy
- Psychiatric Rehabilitation
- Rehabilitation Counseling
- Social Work
- Sociology
- Special Education
- Speech Therapy
- Therapeutic Recreation
- Vocational Rehabilitation

Part 7: Rate Information

a) A customized rate is approved based on either a fixed rate or flexible rate.

- A fixed rate is defined as a rate that has been pre-determined based on input from Health Management Associates, Inc. and is approved based on demonstrated need for either a 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.
- Both the fixed rate and the flexible rate vary by region (Northern vs. Rest of State).

b) Customized Rate funding cannot be requested for a specific dollar amount and does not cover the total cost of what a provider pays their direct support staff. Customized Rate funding first calculates the funding available for staffing in the standard rate model and also takes into consideration the same assumptions as the standard rate model when calculating the costs of approved customized rate staffing.

c) Individuals who are approved for a Customized Rate for 24/7 (i.e., per diem rate) residential supports cannot receive companion services, community coaching, community engagement or group day services during the time that a customized rate is authorized for 1:1 or 2:1 support. In no circumstance should these ancillary services be delivered/billed at the same time that residential supports are being delivered and reimbursed through the customized rate, as this is deemed double billing/duplicative service.

d) Providers are required to submit a schedule of support for the requested 1:1 or 2:1 support hours.

7.1-SPONSORED RESIDENTIAL

a) Customized rate funding approved for Sponsored Residential Supports cannot be used to increase the sponsor payment directly.

b) Funding approved shall only be used to pay for and provide additional staff, not including the sponsor(s), who are necessary to provide the 1:1 or 2:1 supports required to ensure the health and safety of a qualifying individual.

c) Families, caregivers or other individuals who maintain full time residential status in the home where the qualifying individual is receiving services and who are not listed as a sponsored provider can only be included in the customized rate request for additional 1:1 or 2:1 staffing if employment verification (W-2) is provided.

d) Families or caregivers acting as the sponsor are required to provide a minimum of 40 hours weekly of support to the individual before customized rate funding can be approved to cover the cost of paying for or hiring additional staff.

e) Eligible providers must indicate that they have met financial thresholds for paid staff, not including the sponsor as shown below. Providers who are paying *less* than the outlined amount shown are ineligible for sponsored residential customized rate funding. The provider may be requested to provide financial records as verification.

Reimbursement Tier	Rest of State	NOVA
Tier One	0.00	$0.00
Tier Two	$19,200	$25,200
Tier Three	$39,600	$50,400
Tier Four	$67,200	$85,200

7.2-RATE METHODOLOGY

a) In-home Supports

- Rate type: Fixed
- Allowable Supports:
  - 1:1 support with specialized staffing
  - 2:1 support with standard staffing
  - 2:1 support with specialized staffing with one standard staff and one specialized staff
  - 2:1 support with specialized staffing for both staff
- Rate range, ROS: $43.42 - $74.25/hr.
- Rate range, NOVA: $48.50 - $83.32/hr.

b) Community Coaching

- Rate type: Fixed
- Allowable Supports:
  - 1:1 support with specialized staffing
  - 2:1 support with standard staffing
  - 2:1 support with specialized staffing with one standard staff and one specialized staff
  - 2:1 support with specialized staffing for both staff
- Rate range, ROS: $46.33 - $77.84/hr.
- Rate range, NOVA: $51.00 - $86.40/hr.

c) Group Day

- Rate type: Fixed
- Allowable Supports:
  - 1:1 support with standard staffing
  - 1:1 with specialized staffing
- Rate range, ROS: $39.03 - $42.69/hr.
- Rate range, NOVA: $44.49 - $48.69/hr.

d) Sponsored Residential, Group Home & Supported Living

- Rate type: Flexible
- Allowable Supports:
  - 1:1 support with standard staffing
  - 1:1 support with specialized staffing
  - 2:1 support with standard staffing
  - 2:1 support with specialized staffing with one standard staff and one specialized staff
  - 2:1 support with specialized staffing for both staff
  - Higher rate to provide programmatic oversight
- Rate range: Individually determined

Part 8: Application & Processing

A Customized Rate application must be submitted by the provider and can be accessed using the Waiver Management System (WaMS). For technical support regarding navigation of WaMS, refer to the WaMS customized rate user guide which can be found in the 'help' section of WaMS.

a) To submit a Customized Rate application in WaMS, the individual must have:

- A Supports Intensity Scale® (SIS) level {Includes individuals placed in default level 2}
- An Active Enrollment in a waiver program
- An assigned Support Coordinator

b) All applications must be submitted with supporting documentation {See requirements in section 9}. Providers should upload all attachments in WaMS.

8.1-REQUEST FOR PRE-REVIEW OUTSIDE OF WAMS

Providers who wish to request a customized rate but have not accepted the individual into services can submit an application outside of WaMs for pre-review. These applications are reviewed by the committee, however do not substitute for an official application which must be submitted in WaMS. The committee's decision to either approve or deny is based on the information provided at the time of the pre-review and does not guarantee customized rate

funding. Providers are required to submit an official application using the Waiver Management System (WaMS) at which time an official decision will be rendered.

a) Providers requesting pre-review should access the customized rate application (Form 011) located on the DBHDS website: www.dbhds.virginia.gov
b) Supplemental information is required with submission of the application to the extent that it is available. This might include records of hospitalization, documentation supplied by previous providers, support coordinator notes, or records from discharge planning meetings {Refer to section 9-Supporting Documentation}.
c) All applicants are required to submit with their application form SF-20 which can be located on the DBHDS website. Form SF-20 provides information to the reviewing committee related to the provider's program budget, staffing plan and schedule of support.
d) Providers will be required to submit their application for pre-review and their supplemental documentation via email.
e) Providers should send a request to dbhdscustomizedrate@dbhds.virginia.gov to request a secure email prior to application submission. DBHDS typically responds to these requests within the same day by sending a Virtru encrypted email. Once this secure email is received, applications and supplemental documentation should be submitted electronically using the Virtru encryption service provided.
f) Providers will receive a Notice of Pre-Review (NOP) outlining the committee's decision. The NOP form cannot be used as a substitute for an official approval and should not be submitted to service authorization.

Part 9: Supporting Documentation

Providers are required to submit supplemental information which supports the customized rate request as described in the application. Individuals who are new to services can still apply with applicable historical data. Providers should contact the CSB Support Coordinator, family, and previous providers to collect historical data and submit as much information as possible such that the committee can clearly understand the individual's support needs. The following supplemental data should be submitted where applicable and available.

a) **Behavioral Support Plan**-Applicable to all individuals whose primary need for a customized rate is related to challenging behaviors. If not available, the provider is responsible for providing an explanation within the customized rate application.
    - Frequency: Most Recent
b) **Behavioral Data**-Applicable to all individuals whose primary need for a customized rate is related to challenging behaviors. Data should be submitted in such a way that the customized rate committee can easily quantify the frequency, duration and intensity of behaviors. Submission of daily notes is strongly discouraged; providers should make every attempt to submit data that can be quantified.
    - Frequency: Past 6 months & supporting historical data
    - Examples: Graphed behavioral data, crisis reports, history of psychiatric hospitalization, REACH referrals, ABC data
c) **Health Supports Data**-Applicable to all individuals whose primary need for a customized rate is related to high level medical support needs and should include all protocols, medical orders or data which substantiates the support needs listed in the application.
    - Frequency: Past 6 months & supporting historical data
    - Examples: Medical reports, protocols, specialized supervision data, nursing care plan, seizure logs, Medication Administration Records, fall risk assessment, lift/transfer protocols, diabetic protocols
d) **Quarterly Report**-Applicable to applicants. Quarterly reports should summarize the individual's overall accomplishment for the previous 3 months.
    - Frequency: The 2 most recent quarterly reports
e) **Staff Credentials**-Applicable to all providers requesting 'specialized' staffing and/or 'program oversight' and should include the credentials of the staff that will support the individual for whom a customized rate is requested. Please refer to the criteria for the service requested. If scanned, documents must be a high quality, clear scan. It is not necessary to submit credentials if specialized staffing and/or program oversight are not requested.
    - Examples: A copy of licensure, college degree, official transcript, resume. Refer to submission criteria in section 5-6
f) **Crisis Plan**-Applicable to all individuals whose primary need for a customized rate is related to challenging behaviors and should detail direct interventions that avert emergency psychiatric

hospitalizations or institutional placement and include appropriate admission to crisis response services that are provided in the Commonwealth.

- Frequency-Most recent

g) **Overnight Support**-Applicable to all providers requesting overnight supports and should substantiate the provider's request based on the individual's sleep/wake patterns and the overall level of support required to ensure health and safety.
   - Frequency-Past 6 months

h) **Form SF-20**-Applicable to all providers, Form SF-20 documents the provider budget and staffing plan and is critical in the decision making process. This form is located on the DBHDS website; additional instructions are provided within the document.
   - Required with all initial and annual applicants

i) **Incident Reports**- Applicable to all providers. Incident reports should be submitted for any significant events related to the support needs of the individual as described in the application.
   - Frequency-Past 6 months

j) **Staff Training**-Applicable to all providers. Providers should submit evidence of their ability to meet the individual's exceptional support needs through documentation of all that apply; staff training, employment of or contract with an RN, involvement of a behavior or psychological consultant or crisis team and individual-specific training records regarding the individual's medical condition or conditions, medications, risk factors, safety practices, procedures that staff are permitted to perform under nurse delegation, and any other training deemed necessary to enable the individual to be safely supported.
   - Frequency-Most recent

k) **Additional Information**-DBHDS may request additional information at any time to further justify or substantiate the request.

9.1-APPLICATION REVIEW

a) Once it is determined that all necessary information has been provided to substantiate the application, the provider will be contacted and provided the date that a CRRC meeting has been scheduled. Most often, CRRC meetings occur on Wednesday of each week between the hours of 9:00am and 12:00pm {subject to change}.
b) The provider will be requested to be available (by phone) during this time in the event that the committee has additional questions as it relates to the request.
c) The provider point of contact should be listed on the application and must be someone who can speak directly to the individual's support needs and the information which was provided in the application. The committee will only call if there are additional questions that cannot be ascertained within the provided documentation.
d) Applicants whose point of contact is unavailable during the CRRC review meeting will be moved to the next available CRRC meeting date.
e) The CRRC makes every attempt to meet no later than 15 business days of receipt of a completed application; providers submitting for an individual falling in SIS© levels 1-5 will incur a longer waiting period based on the CRC review which must occur prior to the CRRC meeting.
f) Applications are reviewed in the order in which they are received.
g) Applications are approved based on the date that a completed application is received. Applications are not considered complete until all necessary supplemental documentation has been received.
h) Providers who have applications that are inactive in WaMS for longer than 30 days will be notified via form notes that the application will be rejected. Following a 10 day grace period, DBHDS will reject the application. Rejected applications will not have appeal rights.

Part 10: Approvals

10.1-APPROVED APPLICATIONS

The approval criteria requires that the submitting provider has provided sufficient documentation to evidence that:

a) The individual has exceptional medical and/or behavioral support needs;
   And
b) Requires a staffing ratio of 1:1 or higher for the majority of their daily support needs;
   And/or

c) The individual requires specialized staffing to safely and effectively provide direct supports; And/or
d) The individual requires increased programmatic oversight in order to provide the required oversight and supervision of all key programmatic elements related to the individual's exceptional support needs and the individual's exceptional support needs require staff with higher credentials than are routine for a Qualified Developmental Disabilities Professional (QDDP).

10.2-NOTIFICATION

a) Notice of Action- Once a determination has been made by the CRRC, a Notice of Action (NOA) letter will be emailed to the provider using the email listed within the application. The NOA will provide detailed information regarding the recent review of the submitted customized rate application to include a description of the services approved. The reviewing committee may also make certain requirements or recommendations of the provider which will be documented in the NOA. Providers should ensure that the NOA is reviewed in its entirety.
b) Notice of Pre-Review- If a customized rate has been pre-reviewed by the CRRC, a Notice of Pre-Review (NOP) letter will be emailed to the provider using the email listed within the application. The NOP will provide detailed information regarding the recent review of the submitted customized rate request for pre-review to include description of the committee's decision. This form cannot be used as a substitute for the NOA and cannot be submitted to service authorization for approval.
c) Form Notes/Request for Information- Form notes are used to communicate with the provider in WaMS. It is the provider's responsibility to check WaMS frequently and to respond to requests made by DBHDS.
d) Application Closure- Providers who have applications that are inactive in WaMS for longer than 30 days will be notified via form notes that the application will be rejected. Following a 10 day grace period, DBHDS will reject the application. Rejected applications will not have appeal rights.

10.3-DOCUMENTATION REQUIREMENTS

a) All providers who are approved for a customized rate must document throughout the plan year how the approved services have been utilized to support the individual and submit documentation of such supports to include:
   - Evidence of 1:1 and/or 2:1 supports provided to include the frequency and duration of the support.
   - Evidence of the specific supports provided during 1:1 or 2:1 care.
   - Evidence of staff hired as a result of approved customized rate funding, to include credentials for staff approved to provide 'specialized' supports.
   - Evidence of programmatic supports provided.
b) Providers who have been approved customized rate funding shall document in each of the qualifying individuals' plan for supports how that provider will respond to the individuals' specific exceptional needs. Providers shall update the Plan for Supports as necessary to reflect the current status of these individuals. Providers shall address each complex medical and behavioral support need of the individual through specific and documented protocols that may include, for example (i) employing additional staff to support the individual or (ii) securing additional professional support enhancements, or both, beyond those planned supports reimbursed through the standard rate for the specified service.

10.4-ANNUAL REQUIREMENTS

a) All providers who are approved for a customized rate must reapply annually by submitting a new application and the associated supplemental documentation at least 30 days prior to the end of the individual's ISP. Providers who submit their application after this date may incur a gap in customized rate funding during which time the standard rate for the specified service should be billed.
b) Providers should use WaMS to submit their annual application. On the service information page, use the drop down menu to select, 'annual' {Refer to the WaMS Customized Rate User Guide for additional guidance}. Annual applications should be submitted with all of the required supplemental documentation that is required of an initial application to include form SF-20.
c) The annual review date will be based on the individual's service plan year unless otherwise notified in the NOA as with contingent approvals. Providers will be notified of the date and time of the annual review via phone or email.
d) Additional information may be requested from the provider at the time of the annual review to determine if supports have been provided for the previous review period, and/or to determine the continued need of the

customized rate. It is the provider's responsibility to ensure that proper documentation has occurred during the previous review period that indicates that the authorized supports have been provided.

e) The CRRC will often make recommendations to the provider, or provide action steps (noted within the NOA) which must be adopted prior to the individual's annual review. Failure to provide evidence that these actions steps and/or recommendations have been explored and/or adopted at the time of the annual review can result in a denial of the annual request for a customized rate. Listed below are examples of action steps providers might be required to adopt per the NOA:
   - Specific documentation requirements often related to how behavioral or medical supports are documented, measured, and analyzed
   - Evidence of the exploration of other Waiver services
   - Submission of medical protocols
f) Providers are responsible for responding to requests for additional information throughout the year and at random may be asked to participate in an onsite visit with the CRRC or designees.
g) 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
h) Providers are responsible for notifying DBHDS of any changes in the individual's support needs that would affect the continued need for a customized rate and/or result in the need for an adjustment to the customized rate. This includes changes to support needs, changes in SIS© levels, and changes to bed capacity for residential services.
i) 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.
j) DBHDS reserves the right to conduct unannounced site visits which may be conducted with collaboration with the Department of Human Rights and/or the Department of Licensing at any time throughout the plan year.

10.5-CONTINGENT APPROVAL REQUIREMENTS

a) In some cases a customized rate is approved for a time period of less than the full ISP year (Contingent Approval). In these circumstances the provider will be made aware of the slated end date within the NOA.
b) Contingent approvals are typically approved for less than the full ISP year to allow the provider additional time to collect data necessary for a full approval.
c) The NOA will outline what information is necessary for a full approval and provide the slated end date of the contingent approval. The provider is not required to submit a new application for contingent approvals.
d) Providers who are approved for a contingent period should locate in WaMS the application that was approved, locate the attachment section of the application and submit the additional information requested as noted in the NOA prior to the slated end date of the approved contingent customized rate.
e) Providers who fail to submit the requested information by the slated end date will be required to submit a new application and will incur a gap in customized rate funding until the requested information is received. During this time providers will need to bill the standard rate for the requested service.

Part 11: Service Authorizations

a) Approved customized rates replace the standard rate for the service approved.
b) Approvals are retroactive to the date of a completed application received and continue through the individual's plan year, unless otherwise noted in the NOA. The authorized start/end date of the customized rate will be noted on the NOA.
c) Once the NOA has been received, the provider is required to end the current service authorization and submit a new request using the associated service authorization codes.
d) Regardless of the total customized rate approved, providers should ensure that they bill only for the supports and service that they have utilized. Any potential overlaps in billing should be addressed in the Medicaid Enterprise System (MES) and/or directly with DMAS.

e) All service authorization questions or concerns should be addressed directly with your service authorization representative.

11.1-SERVICE AUTHORIZATION CODES

a) Customized Community Coaching-T2013-U1
b) Customized Group Day Support-T2025
c) Customized Supported Living Residential-H0043-U1
d) Customized In-Home Support Services-H2014-U1
e) Customized Sponsored Residential-T2033-U1
f) Customized Group Home Residential-T2016

11.2-FIXED RATE

a) For some services, the rate approved represents an approval for an increase on the base rate only (fixed rate). The total number of hours requested within each service should be submitted to Service Authorization for review and final approval. In example: Individuals approved for community coaching supports with 1:1 standard staffing, living outside of the Northern Virginia area will receive a rate of $47.77/hour. However, the total number of hours requested at this rate must be submitted to Service Authorization for review and final approval.
b) Fixed Rate Services which require additional approval from Service Authorization include:
    - In-Home Supports/ H2014 U1
    - Community Coaching/T2013
    - Group Day/ T2025

Part 12: Denials

a) Providers requesting a customized rate can be denied based on the following:
    - Exceptional support need not demonstrated.
    - 1:1 or 2:1 staffing need not demonstrated.
    - Need for higher qualified staffing not demonstrated.
    - Need for increased programmatic oversight not demonstrated.
    - The CRRC 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 was received.
b) Upon denial, providers will be emailed a NOA which will provide an explanation of the denial.
c) Providers are able to reapply for a customized rate following a 30 day waiting period, if additional information is available to substantiate the request, or if the individual's support needs have changed since the last review. A new application and updated supporting documentation is required.
d) It is important to note that a denial of the customized rate has no effect on the individual's ability to receive the standard rate for the specified service.

12.1-RIGHT TO APPEAL

a) 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, you must file a written notice of appeal with the DMAS Appeals Division within 30 days.
b) Customized rate appeals are applicable to the provider only. Client appeals are not accepted.
c) DBHDS does not govern the appeals process. For any questions regarding appeals, the provider should contact DMAS directly.

12.2-FILING AND APPEAL

A provider may appeal an adverse decision where a service has already been provided. The appeal must be filed with the DMAS Appeals Division through one of the following methods:

a) Through the Appeals Information Management System at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

b) Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/#appealsresources. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
c) Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
d) Email to appeals@dmas.virginia.gov; or
e) Fax to (804) 452-5454.
f) The appeal must be received by the DMAS Appeals Division within 30 days of the receipt of this decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

12.3-APPEALS-NON-DISCRIMINATION

It is important we at DMAS and DBHDS treat you fairly.

a) We will keep your information secure and private.
b) DMAS and DBHDS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
c) DMAS provides free aids and services to people with disabilities to communicate effectively, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). DMAS also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call us at (804) 786-7933 (TTY: 1-800-343-0634).
d) If you believe that this agency has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: Civil Rights Coordinator, DMAS, 600 E. Broad St., Richmond, VA 23219, Telephone: (804) 786-7933 (TTY: 1-800-343-0634).
e) You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://hhs.gov/ocr/office/file/index.html.

12.4-APPEALS-HELP IN ANY LANGUAGE

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 804-786-7933 (TTY:1-800-343-0634).

Español (Spanish)ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 804-786-7933 (TTY: 1-800-343-0634).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 804-786-7933 (TTY:1-800-343-0634)번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 804-786-7933 (TTY:1-800-343-0634).

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 804-786-7933（TTY:1-800-343-0634）。

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 804-786-7933 (رقم هاتف الصم والبكم: 1-800-343-0634).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 804-786-7933 (TTY:1-800-343-0634).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 804-786-7933 (TTY:1-800-343-0634) تماس بگیرید.

አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 804-786-7933 (መስማት ለተሳናቸው: 1-800-343-0634).

Urdu اردو

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 804-786-7933 (TTY:1-800-343-0634).

Français (French)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 804-786-7933 (TTY:1-800-343-0634).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 804-786-7933 (телетайп:1-800-343-0634).

हिंदी (Hindi)

नोट: यदि आप हिंदी बोलते हैं, तो भाषा समर्थन सेवाएं आपको मुफ्त में उपलब्ध हैं। कॉल 804-786-7933 (TTY:1-800-343-0634)।

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 804-786-7933 (TTY:1-800-343-0634).

বাংলা (Bengali)

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 804-786-7933 (TTY:1-800-343-0634)।

Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa)

Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 804-786-7933 (TTY: 1-800-343-0634)

N'ihi na (Ibo)

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 804-786-7933 (TTY:1-800-343-0634).

èdè Yorùbá (Yoruba)

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 804-786-7933 (TTY:1-800-343-0634).

Part 13: Getting Help

Providers should refer to the below listed contact information for additional assistance:

- WaMS-Call the WaMS Help Desk for all "how-to" questions
  - Email: helpdesk@wamsvirginia.org- {7:00 AM – 7:00 PM}
  - Phone: 844-4-VA-WaMS (844-482-9267);
  - Providers should also refer to the Customized Rate WaMS User Guide located in the help section of WaMS.
- DD Service Authorization: (804) 663-7290
- DMAS Provider Helpline: (800) 552-8627
- Customized Rate, general questions
  - Email: dbhdscustomizedrate@dbhds.virginia.gov
- Customized Rate, SIS© Levels 1-5 assessments
  - Email: Gina.koke@dbhds.virginia.gov
  - Phone: (804) 944-7156
- Customized Rate, application status
  - Email: dbhdscustomizedrate@dbhds.virginia.gov
  - Phone: (804-731) 4111
- Customized Rate, denials, approved rates or all other concerns
  - Email: Carrie.ottoson@dbhds.virginia.gov
  - Phone: (804)731-4111
- Appeal Questions Mail or delivery to:
  - Mail-Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
  - Email: appeals@dmas.virginia.gov; or
  - Fax: (804) 452-5454

13.1-FREQUENTLY ASKED QUESTIONS

1. **If I need to submit an application for pre-review, outside of WaMS, how do I ensure that the individual's personal health information is secure?**
   - DBHDS uses Virtru to ensure information is secure when sending. If you are unfamiliar with this service or not registered, you can email: dbhdscustomizedrate@dbhds.virginia.gov and request a secure email. Once received, you will be prompted to register with Virtru.
2. **I use a different secure email server; can I use this service to submit my application?**
   - Unfortunately, we do not accept emails from other servers; however, if you are having difficulty submitting information, please contact us and we will work with you to resolve the problem.
3. **I am accepting a new individual into services that already is approved for a customized rate with another provider. Do I still need to complete a new customized rate application?**
   - Yes, customized rates are approved based on the provider submitted application. Therefore, if the individual is new to your service/home you should submit a new, initial application.

4. **What application should I use?**
    - Providers submitting through WaMS will find a drop down menu located on the service information page of the application. Using the drop down menu, providers should select 'initial' for first time applicants, and 'annual' for renewal applications. Providers seeking pre-review outside of WaMS should refer to the DBHDS website at: www.dbhds.virginia.gov to locate FORM 011.
5. **Approximately how long does the approval process take once the application is received?**
    - Applications are reviewed based on the order in which they are received and typically take less than 30 days from the time a completed application is received. Applicants are processed differently based on the individual's assigned SIS© level. Those falling in SIS© levels 1-5 must be reviewed by a CRC prior to being reviewed by the CRRC. This process can take 1-2 weeks in total and typically includes an onsite review. Individuals who fall in SIS© level 6-7 go directly to the committee for review and typically take less time. It is important to note that applications cannot be reviewed by the CRC or the CRRC until a completed application is submitted. As such, it is important to review the provider guidelines and ensure that applications are submitted with all required supporting data and supplemental documents. Applications that are pended due to missing information can take an extended period of time and are subject to rejection by DBHDS after 30 days of inactivity.
6. **Can we submit a customized rate application for the specified amount of funding that we plan to pay our direct support staff based on the high intensity support needs of the individual?**
    - No, customized rates cannot be requested for a specific dollar amount and are not approved based on the funding need of the provider. Rather, customized rates are approved based on the demonstrated support needs of the individual. However, providers who employ staff meeting criteria outlined in the provider guidelines (See Specialized Staffing) are often approved at a higher rate for 1:1 and 2:1 support hours based on the intensity of the individual's support needs.
7. **Can we request compensation for a manager/supervisor to manage staffing patterns and staff?**
    - Although the customized rate cannot be requested for a specific dollar amount, it is possible that some of the costs associated with employing high level programmatic staff are included within the approved customized daily rate. To qualify, providers must demonstrate that the employed programmatic staff meets minimum qualifications as outlined in the provider guidelines.
8. **Does the application process for customized rates consider approval of funding for a van, electronic devices, employee training or environmental modifications?**
    - No, customized rates are strictly based on the individual's support need, e.g., increased staffing supports, a need for higher qualified staff to provide support, and/or, a need for high level programmatic staff. The customized rate does not consider or cover the costs of any environmental modifications, equipment, cost of living, or business related costs.
9. **I received a contingent approval. Do I need to reapply when the contingent period ends?**
    - No, contingent approvals allow providers additional time to collect data, or adopt specific recommendations made by the committee. These requirements will be outlined in the notice of action form. Prior to the slated end date of the contingent approval, the provider should upload to WaMS the information requested at which time the committee will review the information and if satisfactory, continue the rate through the end of the individual's ISP planning period.
10. **Does the customized rate replace the current rate, or is it approved in addition to the standard rate for the approved service?**
    - The customized rate replaces the current rate for the approved service. When requesting a service authorization for the approved customized rate, providers should end the service authorization for the standard rate for the requested service and submit a new request for the approved customized rate.
11. **How will I know if my customized rate application was approved?**
    - Once a decision has been made a notice is emailed to the provider. The notice of action (NOA) will detail the committee decision and if approved, the rate approved, the number of 1:1/2:1

hours approved, the effective begin/end date, and will also include recommendations which may be required prior to the annual renewal.

12. **An individual new to services might need a customized rate but I don't have any current data. Can I still apply?**
    - Yes, although it is recommended that an individual is served within the service for at least 3 months prior to applying for a customized rate; the customized rate committee understands that this may not always be the best option. Individuals who are new to services or who have not yet been accepted into services can still apply. Providers will need to contact the CSB Support Coordinator, family, and previous providers to collect historical data and submit as much information as possible such that the committee can clearly understand the individual's support needs.
13. **An individual that I serve is currently receiving a customized rate and recently received a change in their SIS© score. Will this affect my rate?**
    - Possibly. Providers are required to report any changes in the individual's status that might result in change to the standard rate. This includes changes in bed capacity for group home services and changes in the individual's SIS© score. However, not all SIS© score changes will result in a change to the customized rate. The provider should notify DBHDS of such changes by emailing: DBHDScustomizedrate@dbhds.virginia.gov
14. **I was denied a customized rate, what are my options?**
    - Providers who were denied a customized rate have two options, (1) reapply following a 30 day waiting period and provide additional information which was not provided previously to support the application and need, or (2) appeal the rate within 30 days to the Department of Medical Assistance Services (DMAS). Note: DBHDS does not govern the appeals process. For any questions regarding appeals, the provider will need to contact DMAS directly.
15. **Where can I find out more about customized rates?**
    - All customized rate forms and guidance documents can be located by visiting our webpage at: http://www.dbhds.virginia.gov/developmental-services/waiver-services