

HOME AND COMMUNITY-BASED SERVICES FOR PEOPLE WITH DISABILITIES

Medicaid Waiver Services Guide



"There's No Place Like Home"

Spring 2004 Edition

Medicaid Waiver Technical Assistance Center
a collaborative project
Independence Center, Norfolk, VA
Virginia Board for People with Disabilities

Medicaid Waiver Services Guide

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Information in this Medicaid Waiver Guide is current as of April 2004. Updates to the Guide will be available in fall 2004. To be added to the update mailing list contact the Endependence Center toll free 866-323-1088 or in Tidewater 757-461-8007 or VaWaivers@endependence.org.

Other documents related to Waivers include:

Regulations for each Home and Community-based Waiver program can be accessed at www.dmas.virginia.gov

Virginia Medicaid Handbook is published by the Department of Medical Assistance Services and can be accessed at www.dmas.virginia.gov or call 804-786-1590.

Understanding Medicaid Home and Community Services: A Primer is published by the U.S. Department of Health and Human Services and can be accessed at www.aspe.hhs.gov/daltcp/reports/primer.htm or call 202-690-6443.

The Virginia Medicaid Waiver Mentors, the Department of Medical Assistance Services, and the Virginia Office for Protection and Advocacy reviewed and commented on drafts of the Guide. We are grateful to them for their time and input.

The Guide was prepared by the Endependence Center, Norfolk, VA.

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Alternative formats of this publication are available.
Call 757-461-8007 or toll free 866-328-1088, or
e-mail VaWaivers@endependence.org.

MEDICAID WAIVER TECHNICAL ASSISTANCE CENTER

Partnership of Private and Public Organizations

866-323-1088 toll free

757-461-8007 Norfolk

VaWaivers@endependence.org

The Medicaid Waiver Technical Assistance Center provides information, materials, workshops, and advocacy meetings about Virginia Medicaid Home and Community-Based Waiver Services. The Medicaid Waiver Technical Assistance Center strives to present information that is understandable and practical.

The Medicaid Waiver Technical Assistance Center was established by 45 community organizations throughout Virginia. The Medicaid Waiver Technical Assistance Center is administered by the Endependence Center in Norfolk and was initiated with a Virginia Board for People with Disabilities grant. The community organizations provide support for advocates from their organizations to conduct workshops and provide information.

Mentors are people in your community who were nominated by disability organizations throughout Virginia. The Medicaid Waiver Mentors are supported by their organization to receive training on Medicaid, to conduct workshops and to provide information about Medicaid Waivers to people in their community. Contact information for the Mentors begins on page 37.

Workshops can be held in your community to share information about Virginia Medicaid Waivers. To schedule a workshop or to find out when the next workshop is scheduled for your community contact one of the Mentors or the Technical Assistance Center.

Individual assistance and information about Virginia Medicaid Waivers are available from the Mentors and the Technical Assistance Center.

An Internet listserve, VAWaivers-L, is used to discuss Virginia Medicaid Waivers. To join VaWaivers-L send a request to VaWaivers@endependence.org.

The Virginia Medicaid Waivers Network advocates for improvement of Virginia Medicaid Waiver services. The Network was established by the Mentors and includes various disability organizations and individuals working together. Meetings are quarterly. For more information contact the Technical Assistance Center.

Materials such as this Guide, workshop handouts, and fact sheets are available.

The Virginia Department of Medical Assistance Services (Virginia's Medicaid agency) has provided training for the Mentors and assistance with the development of materials.

Internet information about Virginia Medicaid Waivers can be also be found at the following sites:

www.dmas.virginia.gov

cms.hhs.gov

www.hcbs.org

Changes to Medicaid Waivers occur occasionally. To receive information about changes, contact the Technical Assistance Center and ask to be placed on the Center's update list.

GLOSSARY

Activities of Daily Living (ADLs) Includes personal care activities such as bathing, dressing, toileting, transferring, and eating.

Appeal Process to challenge decisions with which the person disagrees or if DMAS, the screener or a provider does not act with reasonable promptness to a request for services.

Behavioral Health Authority (BHA) Local government entity responsible for screening people for the MR Waiver and providing access to case management for people with mental retardation. These agencies plan, provide, and evaluate mental health, mental retardation and substance abuse services.

Caregiver A family member or other person who takes primary responsibility for providing assistance to the individual for care he or she is unable to provide for him or herself.

Case Management At the direction of and in partnership with the person receiving services, case management ensures development, coordination, implementation, monitoring and modification of services. Case management is not limited to only people who are receiving Medicaid Waiver services.

Centers for Medicare and Medicaid Services (CMS) Federal office responsible for Medicaid.

Community Services Board (CSB) See Behavioral Health Authority.

Consumer-Directed Services These are services for which the person or their family/caregiver is responsible for recruiting, hiring, training, supervising and firing of the staff.

Consumer-Directed Services Facilitator Responsible for developing documentation and providing training to people to enable them to hire their own attendants, respite workers and companions.

Consumer Services Plan (CSP) Written documents developed by the person receiving services, providers, case manager/support coordinator and others the person wants involved. The CSP includes the services and supports needed, who will provide services, and how often the services will be provided. The CSP must be consented to before it can be implemented. Changes to the CSP require consent of the individual or their family. CSPs are used primarily for services in the DD and MR Waivers.

Cost Effective The cost of home and community-based Waivers must be no more than the cost of services in an institutional setting. Depending on the specific Waiver, either an individual or an aggregate cost calculation is used. Individual cost effectiveness means that the Medicaid expenses for the individual in the community can't exceed what the costs would be if the individual was in an institution. Aggregate cost effectiveness means that the average cost of all people on the Waiver is no more than the average cost of people residing in an institution.

Department of Medical Assistance Services (DMAS) Virginia's State Medicaid agency responsible for administering Medicaid in Virginia. DMAS contracts some activities to other organizations.

Developmental Disability (DD) A severe chronic disability that is evident before the person reaches age 22, is likely to continue indefinitely, is attributable to a disability other than mental illness, results in substantial functional limitations in three or more of the following areas of major life activity: self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living. The term DD includes people with a diagnosis of MR. However, in Virginia there are two separate Waivers for people with DD - the DD Waiver for people with DD that does not include a diagnosis of MR and the MR Waiver for people with DD that includes a diagnosis of mental retardation.

GLOSSARY

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program administered by DMAS for children under the age of 21 according to federal guidelines which prescribe specific preventive and treatment services for Medicaid eligible children.

Health Care Coordination Term used in the Tech Waiver. See Case Management.

Instrumental Activities of Daily Living (IADLs) Activities such as meal preparation, shopping, housekeeping, laundry and money management.

Level of Functioning Survey (LOF) Assessment used to determine if a person needs the level of care provided in an ICF-MR. The LOF is used for determining eligibility for ICF-MR, DD Waiver and MR Waiver.

Medicaid Joint Federal and State program designed to meet the medical needs of certain people who have low income and resources.

Medicare Federal medical benefits financed through the Social Security system primarily for the elderly, but can include others who contributed to Social Security and their children.

Mental Retardation The diagnostic classification of substantial subaverage general intellectual functioning which originates during development and is associated with impairment in adaptive behavior.

Screening Process to determine if a person needs the level of care typically provided in a nursing home or other institution. Screening also includes the requirement that the individual choose to receive their services in an institution or in the community.

Slot An individual funding account for Waiver services. An individual cannot be served under a Waiver unless there is an available "slot."

Social Security Disability Insurance (SSDI) Financial benefits to people with disability. Funds are the FICA social security tax paid on worker's earnings or earnings of their spouses or parents. After a 24-month waiting period, all SSDI beneficiaries are eligible for Medicare benefits.

Spend Down A process to allow people who have more income than normally allowed by Medicaid financial eligibility rules to spend down their excess income on medical expenses. This term is used when DSS is determining financial eligibility for Medicaid in some situations.

State Plan for Medical Assistance (State Plan) Documents that detail Virginia Medicaid eligibility requirements, coverage, reimbursement rates, and administrative policies. Documents are periodically updated. Changes to the State Plan must be approved by CMS. Adding services to the State Plan typically require a commitment of money from the Virginia General Assembly. Medicaid services are sometimes referred to as State Plan services.

Supplemental Security Income (SSI) A federal program that provides cash benefits to people who are elderly or disabled and who have limited income and resources. Funded with general tax revenues.

Support Coordination Term used to describe case management services available to people who qualify for the Developmental Disabilities Waiver, including people on the DD Waiver waiting list. See Case Management.

Uniform Assessment Instrument (UAI) A questionnaire used to assess social, physical health, and functional abilities. The UAI is used to gather information for planning and monitoring of a person's needs and eligibility for certain services. The UAI is used to conduct screening for nursing home and hospital placements and the AIDS, CD-PAS, E&D, and Tech Waivers.

MEDICAID BASICS

Home and Community-Based Medicaid Waiver services are provided to people based on their needs, income and choices. Virginia has six Home and Community-Based Waiver programs. Each Waiver program is targeted toward people who need the type of services often provided in a nursing home or other institution. Each Waiver program offers specific services as listed on page 8. Financial eligibility is a complex calculation of income, resources, assets, and medical and disability-related expenses. Financial eligibility for Medicaid Waivers is more liberal than financial eligibility for other Medicaid services. Waivers provide services so that people can choose to live in the community instead of a nursing home or other institution. Waivers are part of a much bigger Medicaid program.

Medicaid is a joint program between the federal and state governments. Medicaid was established in 1965 by Congress to provide health care primarily to people who have low income and who are elderly, disabled, or pregnant, and families with children. Medicaid is the major funding source for institutional and community services for people with disabilities and the elderly.

Medicare is different from Medicaid. Medicare is a federal program of medical benefits primarily used by the elderly and some people with disabilities. Medicare is financed through the Social Security system. Waivers are not funded by Medicare.

Medicaid covers certain mandatory services for all Medicaid eligible people who need those services. CMS publishes a list of mandatory services that all States must provide. CMS publishes a second list of optional services that States can choose to provide. Once a State chooses to provide a service from the CMS optional list, the State must provide that service to all people who are eligible for Medicaid and who need the service. States can control the cost of Medicaid by limiting the optional services that the State chooses to provide. For instance, Virginia does not choose to provide the optional services of dental or personal care to adults. This is a significant disadvantage to adults in Virginia, but is a way for Virginia to limit the State's cost of Medicaid. The list of Medicaid services available in Virginia can be found in the *Virginia Medicaid Handbook* available at www.dmas.virginia.gov.

State Plan services is a term used to describe the basic Medicaid services available in Virginia. The *State Plan for Medical Assistance* is a collection of documents that details Virginia's Medicaid eligibility requirements, coverage of services, reimbursement rates and administrative policies. The *State Plan* is updated as needed to reflect needed/desired changes. Changes to the *State Plan* must be approved by CMS. Increases or decreases in Medicaid programs require an agreement between the federal and State governments. States are given latitude to design their own programs within federal standards. Non-Waiver Medicaid services are often referred to State Plan or SPO services.

The wealth of the State determines the State's share of Medicaid costs. In Fiscal Year 2003, Virginia paid 49% and the federal government paid 51% of the cost of Medicaid services provided to Virginians. Medicaid expenditures in Virginia were \$ 3,745,873,299.

Eligibility for Medicaid is determined by local offices of the Department of Social Services. Parent income is considered for children who are dependent on their parents unless the child is going to be receiving Waiver services or institutional placement. Parent income is not considered when determining financial eligibility for Waivers or institutional placement. Low income and resource thresholds must be met to be eligible for Medicaid. These thresholds vary depending on medical expenses, size of family and other factors.

Early and Periodic Screening, Diagnosis, and Treatment EPSDT

Early and Periodic Screening, Diagnosis, and Treatment is a federally mandated Medicaid program for children from birth to 21 years of age who qualify for Medicaid. In 1967, Congress established EPSDT to ensure that children were closely monitored to prevent health and disability conditions from occurring or worsening AND to provide services to address such conditions.

The 1999 Medicaid *Primer* produced by the U.S. Department of Health and Human Services which is referenced on the inside cover of this Guide states, "In 1989, Congress strengthened the (EPSDT) mandate by requiring States to cover all treatment services, regardless of whether or not those services are covered in the State's Medicaid plan. The EPSDT component now covers the broadest possible array of Medicaid services, including personal care and other services provided in the home."

Early and periodic screening schedules are determined by DMAS through consultation with medical organizations involved in child health care. These schedules indicate the required minimal frequency of screening services and can be found on the DMAS web site. Screening must include all of the following services:

- √ Comprehensive health and developmental history
- √ Comprehensive unclothed physical exam
 - √ Appropriate immunizations
- √ Lab testing such as lead toxicity screening
- √ Dental, vision and hearing screenings
- √ Other screenings as determined to be needed by a provider
- √ Health education is a required component of screening services.

If there is a concern identified during the screening, the screener must immediately make a referral for a complete diagnostic evaluation. Screening and diagnosis could occur with the same provider.

Treatment must be made available to "correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services" (Title XIX of the Social Security Act.) The list of required services is not exhaustive and includes all services listed in the federal Medicaid program. Some examples of EPSDT treatment services are dental care, eyeglasses, hearing aids, skilled nursing, personal care services, and therapies. Other services that are needed to correct, treat or maintain the child's disability, health problem or medical condition must be provided.

EPSDT is underutilized. EPSDT must be provided to all children who are eligible for Medicaid. EPSDT can be particularly important to children who are on the waiting list for the Developmental Disabilities Waiver or the Mental Retardation Waiver. Receiving services such as skilled nursing or personal care may be needed while the child is waiting for access to the Waiver. Young adults with disabilities between the ages of 18 and 21 often are eligible for Medicaid when they become eligible for SSI. These young adults could especially benefit from EPSDT.

You may find yourself having to educate providers about EPSDT. The DMAS contact for EPSDT is Christopher Owens, 804-786-0342, Chris.Owens@dmass.virginia.gov. Information is available from the National Health Law Program listed on the inside back cover of this Guide. The Mentors can also assist you with EPSDT.

LONG-TERM CARE SERVICES = WAIVERS AND INSTITUTIONS

Medicaid Long-term Care Services include Home and Community-Based Waivers and institutions. Medicaid covers Waivers and institutional placement in nursing homes, hospitals and intermediate care facilities for people with mental retardation (ICFs/MR). Eligibility for an institution is the same eligibility used to determine eligibility for Waivers. If you are not eligible for placement in an institution, you will not be eligible for Home and Community-Based Waivers.

An ICF-MR is an institution for four or more people with mental retardation or other developmental disabilities that offers active treatment and rehabilitation. Virginia has 34 ICFs/MR: 5 large, state-operated ICFs/MR called Training Centers, several hundred people live at each of these Centers and 29 smaller ICFs/MR ranging in size with 4 to 88 people living in these facilities.

To determine eligibility for a Waiver you will first be screened to determine if you need the level of care provided in an institution. You never have to agree to go into an institution. You just have to meet the criteria for placement in the institution. It is your choice whether you want placement in an institution or Waiver services. Different types of institutions have different screening procedures. Waivers are used as alternatives to specific types of institutions. You will be screened for long-term care services that include institutional care and Waivers. Then you choose the type of long-term care services you want: institutional placement or Waiver services.

FINANCIAL ELIGIBILITY FOR MEDICAID LONG-TERM SERVICES IN VIRGINIA

- income equal to or less than 300% of SSI limit (\$1,692 per month in 2004)
- spend down: higher income may be considered for medical expenses for the AIDS, CD-PAS, E&D, and Tech Waivers
- \$2,000 limit of available resources such as savings, stocks and bonds
- parent income and resources do not count regardless of the age of the child

HOME AND COMMUNITY-BASED WAIVERS IN VIRGINIA

- * AIDS Waiver
- * Consumer-Directed Personal Assistance Waiver
- * Elderly and Disabled Waiver
- * Individual and Family Development Disabilities Support Waiver
- * Mental Retardation Waiver
- * Technology Assisted Waiver

DIFFERENT INSTITUTIONAL PLACEMENTS HAVE DIFFERENT WAIVERS

Hospitals are alternatives to
AIDS Waiver
Tech Waiver

Nursing Homes are alternatives to
AIDS Waiver, CD-PAS Waiver
E&D Waiver, Tech Waiver

ICFs/MR are alternatives to
DD Waiver
MR Waiver

MEDICAID WAIVER OVERVIEW

Home and Community-based Waivers were established by the U.S. Congress to slow the growth of Medicaid spending for nursing home care and to address criticism of Medicaid's institutional bias. Congress was responding to the growth in institutional costs and to people with disabilities and their families who objected to being institutionalized as the only means to get support for their needs such as personal care and training. In 1981, Congress amended the Medicaid program to allow for Home and Community-Based Waivers. States were given the option to develop Waiver programs as alternative services for people who were eligible for institutional placement.

Virginia has six Home and Community-Based Waivers. Virginia's first Waiver, the Elderly and Disabled Waiver, was established in 1982. The newest Virginia Waiver is the DD Waiver established in 2000. Waiver programs are approved by CMS initially for three years. Then the Waiver is reviewed by CMS, then revised and renewed through a collaborative application process between CMS and DMAS. A Waiver program application that has been approved by CMS can be amended anytime.

Waivers follow the same basic steps: screening; eligibility; development of a plan for services; enrollment; choosing providers; preauthorization of services; service delivery; annual review and renewal of services. Specific time lines, which agency does what, and services are different between Waivers. Starting on page 19 each Waiver is discussed in detail. Please refer to these Waiver-specific pages for more information about each Waiver. Keep in mind that what you know about one Waiver may not apply to a different Waiver.

All Waivers are not created equal. Some Waivers have a higher cost of living allowance than others. Services vary between Waivers. Some Waivers have restrictive services. For example, personal assistance with the CD-PAS Waiver is limited to 42 hours a week. However, the Elderly and Disabled Waiver has no restriction on the number of personal assistance hours, you receive the number of hours that are needed.

Once you are enrolled in a Waiver, you will receive a Medicaid card. In addition to receiving Waiver services you will receive other State Plan Medicaid services that you are eligible for. Medicaid will be your secondary insurance if you already have other health insurance. In some circumstances, DMAS will reimburse you for some or all of your private health insurance premium through the Health Insurance Premium Payment (HIPP) program. Call 800-432-5924 for HIPP information. Be sure to tell your health care providers that you have Medicaid so that they will not expect you to pay deductibles for Medicaid covered services.

If you had been receiving Medicaid before you were enrolled in the Waiver you may have been receiving your Medicaid services through a managed care program (HMO). Once you are enrolled in the Waiver you will no longer be constrained to using only the providers in the managed care program. All Medicaid providers will now be available for you to choose from.

All Waiver and other Medicaid services must be provided by providers enrolled as Medicaid providers. The only exception to this is consumer-directed services. Consumer-directed service providers (attendants, companions and respite staff) do not have to be Medicaid providers.

Virginia is considering new ways of offering Waiver services. Advocates are working with DMAS to expand consumer-directed services so that more services in Waivers could be either agency-directed services or consumer-directed services. The person would choose which services they want to receive from an agency and which services they want to receive in a consumer-directed manner. DMAS is considering a new model of service delivery, the Independence Plus Waiver, to increase consumer control of services. Contact one of the Waiver Mentors for more information about these expanding opportunities for choice and control.

SERVICE MATRIX VIRGINIA MEDICAID WAIVERS

Services	AIDS Waiver	CD-PAS Waiver	DD Waiver	E&D Waiver	MR Waiver	Tech Waiver
Adult Day Health Care				√		
Assistive Technology			√		√	
Attendant Care (Consumer-Directed)	√	√	√		√	
Companion Services (Agency Directed)			√		√	
Companion Services (Consumer-Directed)			X		√	
Crisis Intervention/Stabilization			√		√	
Day Support			√		√	
Environmental Modifications			√		√	√
Family & Caregiver Training			√			
In-Home Residential Support			√		√	
Nursing Services	√		√		√	√
Nutritional Supplements	√					
Personal Care/Assistance Services	√		√	√	√	√
Personal Emergency Response System			√	√	√	
Prevocational Services			√		√	
Residential Supports					√	
Respite Care (Agency Directed)	√		√	√	√	√
Respite Care (Consumer-Directed)	√		√		√	
Supported Employment			√		√	
Therapeutic Consultation			√		√	

√ - indicates this service is offered under the Waiver specified
 X - expected to be available sometime in 2004

VIRGINIA MEDICAID WAIVER SERVICE DESCRIPTIONS

Adult companion care (agency and consumer-directed) consists of non-medical care, supervision and socialization provided to a functionally impaired adult. Companions may assist or supervise the person with such tasks as meal preparation, laundry and shopping and may also perform light housekeeping tasks which are incidental to the person's care and supervision. This service does not entail hands-on nursing care.

Adult day health care means services designed to prevent institutionalization by providing people with health, maintenance, and rehabilitation services in a daytime group setting.

Assistive technology consists of specialized medical equipment and supplies including those devices, controls, or appliances, specified in the plan of care but not available under the State Plan for Medical Assistance, which enable people to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live or which are necessary to the proper functioning of such items.

Attendant care includes assistance with activities of daily living and instrumental activities of daily living, monitoring of physical health condition, work related personal assistance and the environmental maintenance necessary for people to remain in their homes and in the community. The person will be responsible for recruiting, hiring, training, supervising and firing, if necessary, their attendants. If the person is not able to direct their attendant services, a spouse, parent, adult child or guardian may direct the services.

Case management (also called support coordination) includes assessment, planning, linking, and monitoring of services. Case management (i) ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; (ii) links people with appropriate community resources and supports; (iii) coordinates service providers; and (iv) monitors quality of care.

Consumer-directed personal attendant services (CD-PAS) see attendant care definition.

Crisis stabilization provides intervention to persons with developmental disabilities who are experiencing serious psychiatric or behavioral problems, or both, that jeopardize their current community living situation.

Day support is training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, transportation to and from training sites, services and support activities, and prevocational services aimed at preparing a person for employment.

Environmental modifications are physical adaptations to a house, place of residence, or vehicle. Modifications can also be physical adaptations to a work site, when the modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act. The modification must be necessary to ensure the person's health and safety or enable functioning with greater independence. This service is not used to bring a substandard dwelling up to minimum habitation standards. The modifications must be a direct medical or remedial benefit to the person being served with the Waiver.

Family and caregiver training includes training, education and counseling services provided to families and non-paid caregivers of people receiving services in the DD Waiver. This service includes training, education and counseling services related to disabilities, community integration, family dynamics, stress management, behavioral interventions and mental health.

VIRGINIA MEDICAID WAIVER SERVICE DESCRIPTIONS

In-home residential support is provided primarily in the person's home and includes training, assistance, and supervision in enabling the person to maintain or improve his health, assistance in performing individual care tasks, training in activities of daily living, training and use of community resources, providing life skills training, and adapting behavior to community and home-like environments.

Nutritional supplements are available in the AIDS Waiver. A person may receive enteral nutrition that does not contain a legend drug when it is the person's primary source of nutrition. Primary source means that nutritional supplements are medically indicated for the treatment of the person's condition if the person is unable to take nutrition orally. The person may be either unable to take any oral nutrition or the oral intake that can be tolerated is not enough to sustain life. The focus must be the maintenance of weight and strength commensurate with a person's condition.

Personal care services include assistance with activities of daily living and instrumental activities of daily living, monitoring of physical health condition, work related personal assistance and the environmental maintenance necessary for people to remain in their homes and in the community.

Personal emergency response system (PERS) is an electronic device that enables people to secure help in an emergency. This service is limited to people who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Residential supports are provided primarily in a licensed residence or in the individual's home. This service is one in which support and supervision is routinely provided. Support includes training, assistance, and supervision enabling people to maintain or improve their health, to develop skills in activities of daily living, to use community resources, and to adapt their behavior in community and home-like environments. Reimbursement for residential support shall not include the cost of room, board, and general supervision.

Respite care (agency and consumer-directed) is a service provided to people who are unable to care for themselves. Respite is provided on an episodic or routine basis because of the absence of or need for relief of those individuals residing with the person who normally provide the care.

Nursing services are provided for people with serious medical conditions and complex health care needs who require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the person's home or other community setting on a regularly scheduled or intermittent need basis. Nursing services are ordered by a physician and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse.

Supported employment consists of training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable a person to maintain paid employment.

Therapeutic consultation is provided by professionals in fields such as psychology, social work, behavioral analysis, speech therapy, occupational therapy therapeutic recreation, physical therapy disciplines or behavior consultation to assist people with disability, parents and family members, residential support, day support and any other providers of support services in implementing a plan of care.

YOUR WAIVER SERVICES CHOICES AND CONTROL

- ④ Gather information about the Waiver you qualify for. Read the Regulations for that specific Waiver.
- ④ Services should be individualized to meet your needs and preferences.
- ④ Work with your case manager/support coordinator and providers to discuss your needs and goals. Be candid and clear about your needs and goals.
- ④ Request only those services that are needed now. Your plan can be revised at any time to add needed services or to change services.
- ④ Review information about available providers. If the service is a center-based service, go to the center and observe the program. Ask providers about their expertise and experience with the services you are asking them to provide. Ask to talk with others who are receiving services from them.
- ④ Consider pursuing an appeal if services are denied or if your requests are not acted on with reasonable promptness.
- ④ Keep copies of documentation. Ask for copies of your service plans. You may also want to have copies of the quarterly or semi-annual reports that providers must develop. These documents help to substantiate your need for services. You will want them to reflect your goals and preferences.
- ④ Make your requests in writing. It is fine to request screening, services, and changes verbally. A friendly follow-up letter may help to keep your request moving forward in a timely manner.
- ④ Stay involved in the process to establish and monitor your services.
- ④ Be friendly and persistent. Employees are often busy or distracted. Your guidance is vital if they are going to assist you with planning and delivering services.
- ④ Monitor your services. Providers maintain periodic reports about your services. Most providers develop assessments and reports that include information about the services provided, adequacy of services, progress with goals and objectives, your satisfaction with services, and other individual and personal information. You may want to review this documentation, often referred to as supporting documentation and semi-annual reports.
- ④ If you are told that something won't or can't be provided the provider should give you written documentation explaining why and describing your right to appeal their decision.
- ④ Communicate adequately with providers so that they understand your expectations. Change providers if the provider is not meeting your needs. It is difficult to change providers if there is a lack of providers in your community. This is a tremendous benefit to consumer-directed services; you have the ability to hire individuals that are outside of the traditional provider agency lists.

YOUR WAIVER SERVICES CHOICES AND CONTROL

Current Medicaid Waivers require significant choice and control by the individual. People should be choosing their case management/support coordination agency, service agencies, and services needed. You should control when, where and how you receive services. To a great degree the amount of choice and control you have of your Waiver services will depend on:

- √ Your involvement in the process
- √ Your choice of providers
- √ Availability of providers
- √ Cooperation of providers
- √ Clarity of your choices
- √ Your decisions about services

Before you meet with providers to plan your services, it may be helpful for you to write down your goals for community and independent living. Think through the following questions and be prepared to discuss these with providers:

- What do you need support or assistance with?
- How often do you need the support or assistance?
- How much of the support or assistance do you need?
- Where do you need to receive the support or assistance?
- What happens if you do not receive the appropriate services at the right time in the right manner?

Services should be provided at times, places and in ways that are meaningful and effective for you. Services should be organized around your life - your choices.

The Waiver is yours. It is not the case manager's, support coordinator's or provider's.

CONSUMER-DIRECTED SERVICES

Consumer-directed services are controlled directly by the person with a disability or their family if the person is a child or not capable of managing their staff. You have the choice and control to determine what activities assistance is needed with, who will provide the service, when it will be provided, where it will be provided and how it will be provided.

You will have the flexibility and responsibility to recruit, hire, train, supervise and fire your consumer-directed staff. You will be responsible for completing paperwork to be an employer of the staff that you hire.

Your staff will not work for an agency. They will work directly for you. You will be their employer.

A Consumer-Directed Facilitator will be available to assist you with the employment process so that you can learn how to be an employer and manage your staff.

You will submit time sheets to DMAS/fiscal agent and DMAS/fiscal agent will pay your staff. Based on the time sheets that you submit, a paycheck will be mailed directly to the staff that you have hired.

Consumer-directed services are available in the AIDS Waiver, CD-PAS Waiver, DD Waiver and MR Waiver.

SERVICES TO EXPLORE IN VIRGINIA

EPSDT - Early and Periodic Screening, Diagnosis and Treatment is available to children under the age of 21 who are eligible for Medicaid. Personal care, nursing, therapies and other Medicaid services not typically provided to adults in Virginia are available to children who are eligible for Medicaid. Please see page 5 for more information.

Comprehensive Services Act pools funds from various agencies to meet the needs of children who are "high risk." Decisions about funds and services are determined at the local level by Community Policy and Management Teams (CPMT) and Family Assessment and Planning Teams (FAPT). More information is available by calling 804-662-9815 and on the Internet at www.csa.state.va.us.

Consumer Services Fund is a State fund designed to provide financial assistance for people with physical or sensory disabilities to access services that cannot be funded through other sources. Funds are administered by the Department of Rehabilitative Services (DRS). These funds are dependant on available funding. For more information contact DRS at 800-552-5019 and review www.vadrs.org.

Consumer Support Services are provided through State funds that may be used for services while you are on a waiting list for the MR Waiver. These funds are administered by the Community Services Boards. Community Services Boards provide services to people with mental retardation using a variety of State and local government resources. These services are dependant on available funding. A list of local Community Services Boards is available at www.dmhmsas.state.va.us.

FAMIS - Family Access to Medical Insurance Security Plan is a low cost medical insurance program for the children of working families in Virginia. Based on income, families with uninsured children may enroll in FAMIS. This program covers families that do not qualify for Medicaid. For more information call toll free 1-866-873-2647 or go to www.famis.org.

Consider another Medicaid Waiver if you are on a waiting list. Some people who qualify for the DD Waiver or the MR Waiver may also qualify for one of the other four Virginia Waivers. You can be on a waiting list for one Waiver while receiving services from a different Waiver. You must meet the screening criteria for placement in the institution for which the Waiver is an alternative for.

For example, if you have cerebral palsy and qualify for ICF-MR placement you may also qualify for nursing home placement depending on your needs. If you have an ongoing need for medical management such as glucose level checks or treatment of pressure sores AND if you need significant assistance with activities of daily living you may qualify for the Consumer-Directed Personal Assistance Services (CD-PAS) Waiver or the Elderly and Disabled (E&D) Waiver.

If you are on the waiting list for the DD Waiver, you would maintain your DD Waiver waiting list number and once your number comes up in the DD Waiver system you would be given the opportunity to transfer from the CD-PAS Waiver or the E&D Waiver to the DD Waiver. If you are on the waiting list for the MR Waiver, you would remain on the appropriate (urgent or non-urgent) waiting list while you are receiving CD-PAS or E&D Waiver services until an MR Waiver slot becomes available. Once an MR Waiver slot is available, you would be given the opportunity to transfer to the MR Waiver.

PROCEDURAL SAFEGUARDS RIGHTS AND PROTECTIONS

Procedural safeguards are used to ensure individuals' rights are protected in the Medicaid system. The procedural safeguards are not organized in any specific document. This section of the Guide will provide you with some basic information about your rights regarding appeals, choice, confidentiality, consent, enrollment, human rights, providers, records, planning, waiting lists, and written notice.

APPEALS

Medicaid appeals can be requested to challenge decisions and actions regarding Medicaid. Some examples of issues that can be appealed:

- C when services are denied, reduced or terminated
- C delays in responding to your requests for screening, eligibility and services can be appealed. You have the right to appeal if the case manager/support coordinator, providers or DMAS does not respond with reasonable promptness to your request.
- C inability to secure providers for services that you have been approved to receive.

Appeals must be requested within 30 days of the agency's decision that adversely affects eligibility or services.

Hearing officers should issue a decision within 90 days of your request for an appeal.

Hearing requests should be submitted in writing to the Department of Medical Assistance Services: Appeals Division, DMAS, 600 East Broad Street, Richmond, VA 23219.

You do not need to have an attorney or other person represent you, but such representation is permissible.

The hearing officer will establish a date and time for the hearing. All witnesses will be sworn to tell the truth. The hearing will be recorded and a

written transcript will be made. During the hearing you, or your representative, will present facts and describe why you are appealing. The agency that denied services or delayed a response will be given the opportunity to present facts and respond to the testimony being presented. The hearing officer, the agency, you and your representative will be given the opportunity to ask questions. All information and documentation must be presented at the hearing or a request to leave the hearing record open must be made and accepted by the hearing officer. The hearing officer will write a summary and decision. The summary, decision, all evidence and a transcript of the hearing will be mailed to you.

If you continued to receive Medicaid because you filed an appeal, you may be asked to pay Medicaid back if the appeal is not decided in your favor.

If you do not agree with the hearing officer's decision you can appeal through the courts.

HELPFUL IDEAS-

As described above, DMAS has the formal appeal process to manage complaints and disagreements about Waiver services. You may want to first try a less formal approach to resolving the problem depending on the urgency of your problem. Keep in mind that you only have 30 days to request an appeal. So your informal attempts with phone calls and letters should be done quickly. Then if the problem still exists after your informal attempts to resolve the problem you will be able to submit your request for an appeal before your 30-day time line expires.

PROCEDURAL SAFEGUARDS RIGHTS AND PROTECTIONS

APPEALS - continued

DMAS may not be responsive to your informal attempts to resolve the problem and then you will have to proceed with an appeal if you want to continue to try and resolve the problem.

For example, if you are having difficulty accessing a service from a provider that has been authorized to provide your service, take action. First call the provider, discuss the issue with them and establish a time line for resolution of the problem. If the provider does not resolve the problem by the agreed upon date, call your case manager/support coordinator. If the problem is not resolved in a timely manner, write a letter to the case manager/support coordinator asking them for assistance. In your letter, explain the problem and what you have done to resolve the problem. Keep copies of your letters. Maintain a diary of your efforts to deal with the problem. If the issue is still not resolved, call and/or write DMAS. If the problem persists, submit an appeal to DMAS. Your attempts to resolve the problem will be important evidence in an appeal. Similar steps could be taken for any problem you are having with Waivers.

CHOICE

You have the right to choose your DD Waiver Support Coordination organization.

Case Management for people with mental retardation is provided by the Community Services Boards and organizations that the CSB may choose to contract with.

You have the right to choose all of your Waiver service providers and to change providers.

A list of available providers must be given to you.

Services that are provided should be services that you choose and that you agree are needed.

CONFIDENTIALITY

Case managers, support coordinators and providers must protect the confidentiality of people who receive Medicaid services. Personally identifying information about you cannot be disclosed without your written consent.

CONSENT

Your written consent (or that of your parent or guardian, if appropriate) must be given before Medicaid Waiver services can begin or before services are changed.

FINANCIAL ELIGIBILITY

Financial eligibility for long-term care (Waivers and institutions) is determined by the local Department of Social Services. The Department of Social Services has 45 days to determine eligibility. The 45-day time line begins once you have provided DSS with a completed application and once your case manager/support coordinator or DMAS provide DSS with plan approval documentation. This time line may be longer if disability determination must be made.

Parental income and resources are never considered when determining eligibility for Virginia Medicaid Waivers. This includes children under the age of 18.

DSS will determine if you have a patient pay for your Waiver services.

ENROLLMENT

Individuals must be 6 years or older to qualify for the DD Waiver. Children under the age of 6 who are at developmental risk of significant functional limitations in major life activities may be eligible for the MR Waiver even if they do not have a diagnosis of mental retardation.

PROCEDURAL SAFEGUARDS RIGHTS AND PROTECTIONS

ENROLLMENT - continued

In addition to receiving Waiver services, you will also be eligible for all other Medicaid benefits provided in Virginia. If you have other health insurance, Medicaid will be your secondary insurance.

DSS will annually review your financial eligibility. You will receive notice about this review in the mail and you must respond within the time frame stipulated in the notice.

If you disagree with the DSS decision regarding your financial eligibility, you have the right to appeal. Keep in mind that you have only 30 days to appeal adverse decisions such as the denial of eligibility. If you have missed this 30-day time line you can request another screening and eligibility determination.

HUMAN RIGHTS REGULATIONS

"Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services" are Regulations of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

These Regulations protect the rights of persons receiving services from providers licensed by DMHMRSAS including MR Waiver providers and certain DD Waiver providers (day support, in-home support, and crisis stabilization services). The Human Right Regulations are posted at www.dmhmrzas.state.va.us.

The State Human Rights Committee and Local Human Rights Committees are responsible for addressing alleged violations of the Human Rights Regulations.

PLANNING

Individualized planning is required for all Waivers. Services can be planned in a variety of ways. Some people see this as a very personal process in which they do not want or need others to be involved. Meeting with their case manager/support coordinator and providers separately is what they want and need. Others want to have all of their providers come together in one meeting to discuss services. Some people want intensive, personal meetings to discuss all aspects of their life and to plan in depth for supports and services.

There are different kinds of planning processes that can be used to develop your Waiver and other services. Some examples of planning processes include: Person Centered Planning, Circle of Support, Making Action Plans (MAPS) and Planning Alternative Tomorrows with Hope (PATH). Everyone has unique personalities, needs, perspectives, supports - the type of meeting you will have is your choice.

Waiver services are individualized and personal. Your case manager/support coordinator and providers should work with you to establish the type of meeting you want. You should have planning opportunities that will be meaningful and dignified.

Each Waiver has a process for requesting a change to the plan for your services. Plans must be updated annually. However, a plan can be revised anytime there is a need.

You can move anywhere in Virginia and have your Virginia Medicaid Waiver transfer with you to your new community. Your case manager/support coordinator must assist you with this transfer. If you move out of Virginia, your Virginia Medicaid Waiver does not go with you.

PROCEDURAL SAFEGUARDS RIGHTS AND PROTECTIONS

PROVIDERS

Providers must have the specific knowledge, skills and abilities as described in the Regulations for each Waiver.

Choosing your providers is your right. You should be given a list of all available providers for the services you need.

Changing providers is your right.

You should research and interview providers before making your choice of providers. Case managers and support coordinators can assist you with this. You will want to be comfortable with the agency and the staff that will be assisting you with personal needs and training.

Services should be provided on the days that the services are needed, during the times you need to receive the services. Services must be effective. You may need to choose a different provider if the current provider is not able to provide services when you need them.

Some providers will hire staff that you recruit. If you know of someone who is qualified and who would be a good provider for your services, refer that person to a provider and encourage the provider to hire the person you referred to them.

Providers must give you notice before they terminate their services. Time lines for termination of services by providers varies.

RECORDS

You have the right to review all records and documentation about your Medicaid services including the documentation maintained by your case manager/support coordinator and providers. Copies should be provided to you when requested.

SCREENING

Screening is used to determine eligibility for long-term care (Waivers, nursing homes, long stay hospitals, and ICFs-MR).

Screening must occur if requested. If the screener denies the opportunity to be screened then the screener must provide you with written notice of why the screening was denied. You have the right to appeal the denial of your screening request.

Screening must occur with reasonable promptness. If the screener does not act with reasonable promptness, you have the right to appeal the delay.

Screening must be free. You cannot be charged for screening to determine if you are eligible for Medicaid services.

There are two separate parts of the eligibility process. First, screening determines if you meet the criteria for long-term care (Waiver and institutions). Next, financial eligibility is determined by the local Department of Social Services.

WAITING LISTS

The MR and DD Waivers have waiting lists. No other Medicaid Waivers or Medicaid services in Virginia have waiting lists.

You have the right to be informed in writing if you are placed on a waiting list. For the DD Waiver, DMAS will provide you with a waiting list number. The MR Waiver has two waiting lists - urgent and non-urgent. The CSB will inform you in writing if you are placed on a waiting list.

You can be on another Waiver while you are on a waiting list for the DD or MR Waivers. You must meet the criteria for placement in the institution that is an alternative to the Waiver you receive.

PROCEDURAL SAFEGUARDS RIGHTS AND PROTECTIONS

WRITTEN NOTICE

To ensure effective, meaningful participation in all aspects of screening, eligibility, planning and service delivery people need to be provided details about these activities. The different Waivers have different requirements regarding when notice must be provided and how the notice must be provided.

If any organization denies screening, eligibility, specific services or the amount of services you are seeking, that organization must provide the denial in writing. You can appeal these denials.

Requested services must be provided unless it can be shown that you do not need the services or that the services are not covered by Medicaid. Services can be denied if the case manager, support coordinator or DMAS believes you do not need the service and if you do not prevail in an appeal. You have 30 days to appeal a denial of services.

Written notice must include:

- C what action the agency intends to take;
- C reason for the intended action;
- C specific regulation or law that supports the intended action;
- C the right to an evidentiary hearing, and the methods and time limits for doing so;
- C the circumstances under which benefits continue if a hearing is requested; and
- C the right to representation.

If an agency fails to provide you with written notice in response to your request for eligibility or specific services you can request an appeal of the agency's failure to act with reasonable promptness.

OLMSTEAD PLANNING IN VIRGINIA

The Americans with Disabilities Act requires "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." A 1999 U.S. Supreme Court decision, *Olmstead vs L.C.*, stated "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable for unworthy of participating in community life." The court ruled that States cannot discriminate against people with disabilities by providing long-term care services only in institutions when people could be provided services in the community.

Federal agencies and many States are taking specific actions to reform policies and practices to ensure that people with disabilities have meaningful choices about where and how services are provided. In Virginia, the General Assembly required the convening of an Olmstead Task Force "to develop a plan for serving persons with disabilities that implements the recommendations of the Olmstead decision. The task force shall submit its final recommendations to the Governor, the Chairmen of the House Appropriations and Senate Finance Committees, and the Chairman of the Joint Commission on Health Care by August 31, 2003."

The Virginia Olmstead Task Force had seven Issues Teams addressing accountability, educating the public, employment, housing, prevention and transition services, qualified providers and Waivers. Planning to address the recommendations from the Task Force is ongoing. Information is available at www.olmsteadva.com.

AIDS WAIVER

Jeff lives with his family and works part-time with a local school district. When he was 39 years old he was diagnosed with acquired immunodeficiency syndrome (AIDS). After a period of time Jeff was no longer able to work because of health-related issues. He applied for and began receiving Social Security Disability Insurance (SSDI). Over a period of time Jeff's health required him to have assistance with personal care. He contacted the local AIDS organization to see what services were available. The organization told Jeff that he might be eligible for services in a nursing home or for home and community-based services. Jeff requested a nursing home screening from his local Department of Health. It was determined that Jeff needed the level of care available in a nursing home, but Jeff did not want to live in a nursing home. He wanted to continue to live in his home, with his family and receive services in his home. Jeff opted to receive AIDS Waiver services.

Today, Jeff lives at home and receives daily support services through the AIDS Waiver. His health has stabilized and he is now working at his old school job part time and earning \$1,600 a month. These wages are low enough to continue his AIDS Waiver eligibility. The school district continued the district's health insurance so Medicaid is Jeff's secondary insurance program. His employee health insurance pays for most of his health care cost with Medicaid paying medically necessary costs that are not covered in full by his private insurance. This has been a good benefit because his private insurance only covers a limited amount of prescription costs a year and then Medicaid will cover the remainder of the prescription costs.

One of Jeff's medications is provided intravenously. The AIDS Waiver provides skilled nursing services to assist with the administration of these medications and monitoring Jeff's health condition. Jeff has remarkably reduced gross motor skills and needs daily personal care services for assistance with bathing and dressing. The AIDS Waiver provides resources so that Jeff can hire an attendant to assist him for three hours every evening. There are periods of time when Jeff's health deteriorates and he needs additional skilled nursing and personal care services. A case manager at the AIDS organization assists him to access services when they are needed. Jeff is in control of his services. He determines what agency he wants to use for skilled nursing and when he wants them to come to his home. He hires and supervises the individuals he wants to provide his personal care services.

Jeff enjoys the productivity of working, staying involved with his family and friends in the community, and living his own home.

AIDS Waiver Services

Case management
Consumer-Directed Attendant Care and Respite
Nutritional supplements (if this is the primary source of nutrition and not available through any other food program)
Personal care
Private duty nursing
Respite care (720 hours maximum a year)

AIDS Waiver Services

WHO	Individuals with a diagnosis of AIDS and symptomatic or HIV who meet level of care requirements for admission to a nursing facility or hospital.						
FINANCIAL CONSIDERATIONS							
Monthly income limits	Up to 300% of SSI, \$1,692 per month maximum income in 2004						
Resource limits	Individuals can have up to \$2,000 of resources such as savings and bonds.						
How is financial eligibility determined?	By the local Department of Social Services (DSS) the individual has been determined to meet AIDS Waiver eligibility by the Nursing Home Pre-admission Screening team. The eligibility determination process with the local DSS may take up to 45 days.						
Are there co-pay requirements?	No						
Is a spend down available?	Yes, this is determined by the local DSS during eligibility determination.						
SCREENING							
How is a screening initiated?	A pre-admission screening is requested by the recipient or other party by contacting the Nursing Home Pre-Admission Team within the local Departments of Health and Social Services. If an individual is in a hospital, the individual should contact the hospitals discharge planner for the unit.						
Who conducts the screening?	For individuals in the community, the local Nursing Home Pre-Admission Screening Team consists of a registered nurse, social worker, and a physician. For individuals in the hospital, the screening team consists of a social worker and a physician.						
What is the screening criteria?	The Nursing Home Pre- Admission Screening Teams use the nursing facility level of care criteria to determine Waiver eligibility.						
What survey is used to determine eligibility?	The Uniform Assessment Instrument (UAI), Nutritional Status Evaluation Form, and a physician's order (unless it is written on the Nutritional Status Evaluation Form).						
CASE MANAGEMENT							
Is case management provided?	Yes. Case Management is an AIDS Waiver service.						
What entities provide case management?	AIDS Support Organizations and other approved Medicaid AIDS Waiver providers						
STATISTICS for Fiscal Year '03 July 2002-June 2003	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding-right: 20px;">Peoples served by the Waiver</td> <td style="text-align: right;">277</td> </tr> <tr> <td>Waiver costs</td> <td style="text-align: right;">\$ 946,873</td> </tr> <tr> <td>Other Medicaid costs</td> <td style="text-align: right;">\$ 4,964,634</td> </tr> </table>	Peoples served by the Waiver	277	Waiver costs	\$ 946,873	Other Medicaid costs	\$ 4,964,634
Peoples served by the Waiver	277						
Waiver costs	\$ 946,873						
Other Medicaid costs	\$ 4,964,634						
HISTORY	<p>First approved in January 1991</p> <p>The AIDS Waiver is in the process of renewal with CMS.</p>						

CONSUMER-DIRECTED PERSONAL ASSISTANCE SERVICES WAIVER

Shelby has lived with her roommate for two years. They are good friends, share living expenses and know when to give one another space. Shelby has worked at the mall for about four years. She works 30 hours a week and earns about \$1,600 a month. Her employer provides health insurance; however, the health insurance doesn't cover many of her needs. Shelby has cerebral palsy. She uses a wheelchair for mobility and an electronic communication device. She needs an attendant to assist with some activities such as bathing, dressing, cooking, cleaning and shopping.

During one of Shelby's transition meetings at school someone told her about Medicaid home and community-based Waivers. Shelby and her parents asked about Medicaid but were told that she would not qualify because her parents made too much money. Of course, now she knows better - parent income doesn't count when a child or adult applies for a Medicaid Waiver.

Shelby went to her local Department of Social Services and asked to apply for the CD-PAS Waiver. No one knew what she was talking about. Acting on a tip from an advocate, she rephrased her question - "I would like to be screened for nursing home care." Well, now the Department of Social Services knew what she wanted, they know nursing home placement. As the screening proceeded, the social worker asked her questions about everything from how long it takes for her to eat to how she cleans the kitchen. A nurse also asked questions. They declared her eligible for placement in a nursing home. Shelby knew what was coming next, the marvelous choice form. Did she want placement in a nursing home, or did she want home and community-based services? Without hesitation, Shelby checked the line for home and community-based services. The social worker gave her a list of personal care agencies to choose from. Again, her earlier discussion with an advocate paid off. Shelby explained to the social worker that she did not want a list of agencies, she wanted the CD-PAS Waiver. The social worker was not sure what to do next. They scheduled another meeting. They met, another form, questions about her ability to manage her own care. Then another list - different from the first list of agencies she had been given at their first meeting. This list was of Consumer-Directed Facilitators. Shelby picked the only Facilitator in her area of Virginia, wondering why she was given the list - not much of a choice she thought. A few days later the CD Facilitator called her, asked even more questions, they met, she waited a couple of weeks, met with the Facilitator again to learn about how to recruit, hire, train, supervise and fire her own staff of personal care attendants. Shelby hired people she knew to be her attendants, people she trusted. When she has questions about the process of selecting, hiring and time sheets, Shelby calls her CD Facilitator.

Shelby receives regular Medicaid benefits in addition to the CD-PAS Waiver. Her employer's health insurance doesn't cover items like her specialized wheelchair and communication device. She is able to get these items through her Medicaid benefits.

Shelby chooses who will provide her assistance. When, how, where are all her decisions. If an attendant works well, like most employees they will stay employed. Shelby does what she chooses to do, she works, she has control of her life.

Consumer-Directed Personal Assistance Services Waiver Services

Consumer-Directed Personal Assistance (42 hours maximum a week)

CONSUMER-DIRECTED PERSONAL ASSISTANCE SERVICES WAIVER

WHO	Individuals who are age 65 and older or who are disabled and meet level of care requirements for nursing facility placement. Individuals must be able to hire, train, supervise, and if necessary, fire, their attendant. OR If the individual is incapable of directing their services a spouse, parent, adult child or guardian may direct services on behalf of the individual.						
FINANCIAL CONSIDERATIONS Monthly income limits Resource limits How is financial eligibility determined? Are there co-pay requirements? Is a spend down available?	Up to 300% of SSI, \$1,692 per month maximum income in 2004 Individuals can have up to \$2,000 of resources such as savings and bonds. By the local Department of social Services after the individual has been determined to meet CD-PAS Waiver eligibility by the Nursing Home Pre-admission Screening team. The eligibility determination process with the local Department of Social Services (DSS) may take up to 45 days. Yes. If an individual has earned or unearned income above 100% of SSI, remaining amount is subject to a co-pay. If the individual is employed 8-20 hours per week, the individual can keep up to 200% of SSI before a co-pay is assessed. If the individual is employed 20 or more hours per week, the individual can keep up to 300% of SSI before a co-pay is assessed. In any situation, an individual's combined earned and unearned income cannot exceed 300% of SSI. Yes, this is determined by the local DSS during eligibility determination.						
SCREENING How is a screening initiated? Who does an individual contact to begin the screening process? Who conducts the screening? What is the screening criteria? What survey is used to determine eligibility?	An individual or family requests to be screened through their local health or social services department. The individual contacts the Nursing Home Pre-Admission (NHPAS) Team within the local departments of Health and Social Services. If an individual is in a hospital, the individual should contact the hospital's discharge planner. For individuals in the community, the local Nursing Home Pre-Admission Screening Team consists of a registered nurse, social worker, and a physician. For individuals in the hospital, the screening team consists of a social worker and physician. The Nursing Home Pre-Admission Screening Teams use the nursing facility level of care criteria to determine CD-PAS Waiver eligibility. In addition, "A Questionnaire to Assess An Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver" form is completed if the individual is interested in CD-PAS Waiver. The Uniform Assessment Instrument (UAI) is used for the CD-PAS Waiver.						
CASE MANAGEMENT	Not provided						
STATISTICS for Fiscal Year '03 July 2002-June 2003	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">People served by the Waiver</td> <td style="text-align: right;">162</td> </tr> <tr> <td>Waiver costs</td> <td style="text-align: right;">\$ 2,690,983</td> </tr> <tr> <td>Other Medicaid costs</td> <td style="text-align: right;">\$ 1,210,822</td> </tr> </table>	People served by the Waiver	162	Waiver costs	\$ 2,690,983	Other Medicaid costs	\$ 1,210,822
People served by the Waiver	162						
Waiver costs	\$ 2,690,983						
Other Medicaid costs	\$ 1,210,822						
HISTORY	First approved in July 1997 The next renewal is due July 2007.						

DEVELOPMENTAL DISABILITIES WAIVER

Steve is a curious and energetic young boy. His family is in awe of the amount of activity he engages in every day. Steve's family consists of two parents, four children and some pets. They live in the country and have many extended family members in the same county. When Steve was a toddler his parents noticed that his developmental milestones were somewhat different from their first two children. At the age of three, Steve was diagnosed with autism. Soon after he began special education preschool services in a school about one hour from home. Now at the age of eight Steve is still going to that same school. His parents have recently begun to talk with the school about transferring Steve to the school his siblings attend which is less than ten minutes from their home. Steve's siblings are protective of him and like to include him in their play activities. However, as Steve has gotten older, his siblings have a more difficult time interacting with him.

When Steve was six years old his parents received a newsletter in the mail that described the new Individual and Family Developmental Disabilities Support Waiver. There was a form in the newsletter that the family could use to request a screening for this new Waiver. They filled out the form and mailed it to the State Medicaid agency, Department of Medical Assistance Services in Richmond. Several months later the local developmental clinic with the Department of Health called to schedule a meeting to conduct the screening. The clinic staff came to Steve's home for the screening. Steve's parents had gathered his IEPs and school evaluations, as another family who had already gone through the screening process had recommended. During the screening Steve and his parents were asked a series of questions about what Steve could do and how much assistance he needed for various activities. Steve was asked to demonstrate some skills such as identifying coins and the President of the United States. At the conclusion of the screening, the staff said that Steve was eligible for intermediate care facility/ institutional placement because of his level of need. The staff asked Steve's parents to indicate on a choice form if they wanted services in an institution or in the community. They indicated they wanted home and community-based services, DD Waiver. They were then provided a list of support coordination agencies that would provide case management and assist them in developing a Consumer Services Plan and accessing services. The parents called people they knew who were already receiving support coordination and asked them about the different agencies. They selected an agency off the list and informed the clinic staff of their decision. A few days later the support coordinator called them and a Consumer Services Plan was developed after a couple of meetings with Steve, his family and friends. Within seventy days the Consumer Services Plan was approved by DMAS, Medicaid eligibility was determined, service providers were chosen by Steve's parents, services were preauthorized and services were starting.

After a year of receiving services, the family began to settle into an improved routine of having supports so that Steve could become more interactive, behaviors were less challenging and he began to learn new independent living skills. Alarms were installed on the entrances to the home so that his family would know immediately if he went outside. In-home residential support provided Steve with training to keep his bedroom neat, behavioral strategies, grooming and eating skills. These in-home services were scheduled so that he received fewer services on school days and more services on nonschool days. The family received training on how to assist and interact with Steve so that he could be more responsive. Steve's parents received Consumer-Directed Respite for a break from their ongoing caregiving responsibilities. Extended family members were trained to provide these respite services. The support coordinator provided advocacy guidance to the family so that they could approach the school about transferring to their neighborhood school so that Steve could go to school with his siblings and no longer have a lengthy and disruptive bus ride.

Steve and his parents are preparing for their second year of DD Waiver services. Steve, his parents, his support coordinator and service providers are reviewing the success of the current services and will be determining if the same, additional or different services are needed. The Department of Medical Assistance Services will be meeting with them sometime during the year to conduct a new assessment, just like the assessment conducted by the local Department of Health, to determine if Steve still meets the eligibility criteria for the DD Waiver. Steve is gaining new skills. His family is more assured that they are providing him with opportunities for developing social and independent living skills.

Developmental Disabilities Waiver Services

Adult companion services (8 hours maximum a day)
Assistive Technology (\$5,000 maximum a year)
Crisis Stabilization (60 days maximum a year)
Day support (780 units maximum a year)
Environmental modifications (\$5,000 maximum a year)
Family/caregiver training (80 hours maximum a year)
In-home residential support (not congregate, not group home)
Personal assistance services (Consumer-directed & agency)
Respite Care (Consumer-directed & agency) (720 hours maximum a year)
Skilled nursing
Supported employment (780 units maximum a year of day)
Therapeutic consultation

WAITING LIST FOR THE DD WAIVER

People request a screening for the DD Waiver by submitting a screening request form to DMAS. DMAS assigns a waiting list number to people who request a screening. Waiver slots are assigned to people based on waiting list numbers first come, first served. DMAS maintains the waiting lists. Even though there are waiting lists, people who need DD Waiver services should request a screening so that they can obtain a waiting list number.

As of April 2004, approximately 2,000 people had requested screening for the DD Waiver. About 40% of the people requesting screening are not eligible for the DD Waiver for reasons such as they have a diagnosis of MR, they are less than six years old, or they do not need the level of care provided in an ICF-MR.

There are two levels of funding for the DD Waiver - Level 1 and Level 2. Level 1 represents service needs less than \$25,000 a year for the individual. 55% of available funding is used for Level 1 needs. Level 2 represents service needs that are more than \$25,000 a year for the individual. 40% of available funding is used for Level 2 needs. 5% of the available funding is used to fund emergency needs. There are separate waiting lists for each Level of funding.

Subject to available, funding, people must meet at least one of the emergency criteria below to be eligible for immediate access to DD Waiver services without consideration to the length of time a person has been waiting to access services. As of October 2002, all emergency funds had been used and no additional emergency needs were being funded. The emergency criteria are:

1. The primary caregiver has a serious illness, has been hospitalized or had died;
2. DSS has determined the individual has been abused or neglected and is in need of immediate services;
3. The individual has behaviors which present risk to personal or public safety; or
4. The individual presents an extreme physical, emotional or financial burden and the family is unable to provide care.

The DD Waiver Support Coordinator assists the individual in documenting the emergency need and submits documentation to DMAS to request emergency access to the DD Waiver.

INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER

WHO	Individuals age 6 and older or who have a developmental disability and who do not have a diagnosis of mental retardation						
FINANCIAL CONSIDERATIONS Monthly income limits Resource limits When is financial eligibility determined? Are there co-pay requirements? Is a spend down available?	Up to 300% of SSI, \$1,692 per month maximum income in 2004 Individuals can have up to \$2,000 of resources such as savings and bonds. By the local Department of Social Services after the individual has been approved by DMAS for DD Waiver services. This process can take up to 45 days. Yes. If an individual has earned or unearned income above 100% of SSI, remaining amount is subject to a co-pay. If the individual is employed 8-20 hours per week, the individual can keep up to 200% of SSI before a co-pay is assessed. If the individual is employed 20 or more hours per week, the individual can keep up to 300% of SSI before a co-pay is assessed. In any situation, an individuals combined earned and unearned income cannot exceed 300%of SSI. No						
SCREENING How is a screening initiated? Who does an individual contact to begin the screening process? Who conducts the screening? What is the screening criteria? What survey is used to determine eligibility?	An individual requests to be screened for the DD Waiver by completing a "Request for Screening" Form and sending the form to DMAS. The form can be accessed at the DMAS website, www.dmas.virginia.gov Once DMAS receives the form, DMAS generates a letter to the applicant and informs the applicant of the applicant's lottery number. The request form is then sent by DMAS to the nearest Child Development Clinic. Virginia Department of Health Child Development Clinics. There are 11 clinics located around the Commonwealth. The same criteria used to evaluated an individual's eligibility for placement in an ICF-MR. The individual must meet two out of seven levels of functioning in order to qualify, in addition to the other requirements previously described. Level of Functioning Survey						
CASE MANAGEMENT Is support coordination provided? What entities provide support coordination?	Case Management is called Support Coordination in the DD Waiver. Yes. Support Coordination is a State Plan service. Organizations or individuals who contract with DMAS as a provider.						
STATISTICS for Fiscal Year '03 July 2002-June 2003	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">People served by the Waiver</td> <td style="text-align: right;">241</td> </tr> <tr> <td>Waiver costs</td> <td style="text-align: right;">\$ 3,589,518</td> </tr> <tr> <td>Other Medicaid costs</td> <td style="text-align: right;">\$ 1,425,768</td> </tr> </table>	People served by the Waiver	241	Waiver costs	\$ 3,589,518	Other Medicaid costs	\$ 1,425,768
People served by the Waiver	241						
Waiver costs	\$ 3,589,518						
Other Medicaid costs	\$ 1,425,768						
HISTORY	First approved by CMS in June 2000 The DD Waiver was renewed in 2003. Changes expected to be implemented in 2004.						

ELDERLY AND DISABLED WAIVER

Harold has just enrolled in his first year of college. He has learned to use his own schedule. He comes and goes as he pleases. This is very different from his life just two years ago. Harold had been living in a nursing home, eating when he was told to eat, having to sign out before he could leave to go to see friends, little about his life was independent or satisfying.

When Harold was six years old he was in a car accident that resulted in paralysis of his legs and much of his upper body. After the accident he left the hospital and went home to live with his single mother. She provided for all of his personal care the best she knew how. As he grew, his mother developed problems with her back. They left their home in a rural community and moved to a large city with the hope of finding support services. The move was expensive and his mother began to work two jobs. Eventually she was not able to provide him with the care he needed on a routine basis. Her work schedule made her unavailable at the times he needed her and back problems now prevented her from lifting him. Harold and his mother requested help from school, from physicians, from therapists. When no one could provide the help they needed, Harold moved into a nursing home at the young age of 16. He attended high school and graduated while he was living in there. With his future before him, Harold became determined to get out of the nursing home. He met someone who was living in the nursing home who was planning to leave. They talked, Harold learned about Medicaid Waivers, and he requested a screening for the Elderly and Disabled Waiver from the nursing home's social worker. He was screened, He got out.

Working with a Center for Independent Living, Harold began to plan what he called his "escape" from the nursing home. He had no money, no furniture, only five sets of clothes, no groceries, no shampoo - you get the picture. A local housing authority provided a Section 8 housing voucher that would assist with his monthly rent. Working with local advocates he was able to pull together money to pay for his rental deposits, buy furniture and household items and stock his food pantry. He had never lived on his own and he had some anxiety about this. He met with other young people with disabilities who were living on their own. This provided him with peer support, ideas, and the confidence to make the move.

Harold uses the E&D Waiver for personal care services. At his screening, he was provided a list of personal care agencies. He researched the agencies on the list to find one that would meet his needs and that he felt comfortable with. He met with them to tell them what he would need assistance with, when he needed the assistance each day, and how he wanted them to assist him. It took several attempts to find the right agency and the right staff that he liked but eventually Harold settled on the agency and staff he felt would be best. The E&D Waiver also provided Harold with a personal emergency response system (PERS). This is a device that he wears around his wrist or neck with a button he can push to reach emergency assistance in case he is in a situation at home in which he cannot get to his telephone to call for help.

Sometimes the personal care staff do not show up to work and Harold is left without assistance. His family will come to his home and assist him when the agency fails to provide staffing. This happens often and Harold would like to find a more dependable agency. Harold needs 57 hours a week of personal care services. The CD-PAS Waiver only allows individuals to have 42 hours of services a week, too few to meet his needs. Harold qualifies for the DD Waiver. He is on the waiting list for the DD Waiver. So for now, the E&D Waiver allows him to be out of the nursing home. He may not be able to get to classes if staff do not come to get him out of bed in the morning on time. He may not be able to be employed because of the lack of dependable staff. Harold sees the E&D Waiver as a stepping stone. He is out of the nursing home. He is developing independent living skills.

Someday his waiting list number will come up and he will have access to the DD Waiver. Harold then will be able to customize supports he can depend on so that he can get to work every day, on time. Customized supports will allow Harold to be spontaneous and change his schedule when he needs to, attend his child's soccer game, or pick up groceries on the way home. With a Medicaid Waiver, Harold's life is under control, as it should be. His own apartment. His own rules. His own schedule. His life.

Elderly and Disabled Waiver Services

Adult Day Health Care

Personal Care Services

Personal Emergency Response System (PERS) (only for people 14 and older)

Respite (720 hours maximum a year)

DMAS is working on changes to the E&D Waiver that will likely be effective in 2004.

QUALIFYING FOR THE AIDS, CD-PAS AND E&D WAIVERS AND NURSING HOME PLACEMENT

People who meet nursing home criteria may choose to receive services through the AIDS, CD-PAS or E&D Waivers if they qualify for one of those Waivers. Each of these Waivers has different eligibility criteria in addition to the following nursing home criteria. To determine if a person meets nursing home criteria, the screening team must consider the following factors:

- Functional capacity, extent and type of individual needs for assistance
- Coping ability and resources of the person's support system
- Other demands already placed on the person's support system
- Other available community resources
- Medical or nursing needs
- Person's risk of nursing home placement in the absence of Waiver services.

Children can meet this criteria. Children can be screened for nursing home placement and receive nursing home criteria Waivers if the child is eligible based on the factors listed above.

The person must be determined to be at risk of nursing home placement unless Waiver services are offered. However, you never have to agree to be placed in a nursing home. You just must need the level of care typically provided in a nursing home.

Except as provided for people who require the daily direct services of a licensed nurse that cannot be managed on an outpatient basis, a person may only be considered to meet the nursing home criteria when both the functional capacity of the person and his or her medical or nursing needs meet specific requirements.

Functional capacity is assessed using the Uniform Assessment Instrument (UAI). Functional capacity is assessed regarding bathing, dressing, toileting, transferring, bowel function, bladder function, eating/feeding, behavior pattern and orientation, joint motion, mobility, medication administration, and instrumental activities of daily living.

More information about nursing home screening criteria is in the DMAS *Nursing Home Pre-Admission Screening Manual*. The *Manual* and UAI are available at the DMAS web site.

ELDERLY AND DISABLED WAIVER

WHO	Individuals age 65 and older or who are disabled and meet level of care requirements for admissions to a nursing facility. The Elderly and Disabled Waiver is available to young people who meet the criteria for nursing home admission.						
FINANCIAL CONSIDERATIONS Monthly income limits Resource Limits When is financial eligibility determined? Are there co-pay requirements? Is a spend down available?	Up to 300% of SSI, \$1,692 per month maximum income in 2004 Individuals can have up to \$2,000 of resources such as savings and bonds. By the local Department of Social Services after the individual has been determined to meet E&D Waiver eligibility by the Nursing Home Pre-admission Screening team. The eligibility determination process with the local DSS may take up to 45 days. Yes. If an individual has earned or unearned income above 100% of SSI, remaining amount is subject to a co-pay. There are no earned income disregards in the E&D Waiver. Yes, this is determined by the local DSS during eligibility determination.						
SCREENING INFO How is a screening initiated? Who does an individual contact to begin the screening process? Who conducts the screening? What is the screening criteria? What survey is used to determine eligibility?	A pre-admission screening is requested by the recipient or other party to the local Department of Social Services or local Health Department. The individual contacts the Nursing Home Pre-Admission Team within the local departments of Health and Social Services. If an individual is in a hospital, the individual should contact the hospital's discharge planner for the unit. For individuals in the community, the local Nursing Home Pre-Admission Screening Team consists of a registered nurse, social worker, and a physician. For individuals in the hospital, the screening team consists of a social worker and physician. The Nursing Home Pre-Admission Screening Teams use the nursing facility level of care criteria to determine E&D Waiver eligibility. The Uniform Assessment Instrument (UAI)						
CASE MANAGEMENT	Not provided						
STATISTICS for Fiscal Year '03 July 2002-June 2003	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">People served by the Waiver</td> <td style="text-align: right; padding: 2px;">9,950</td> </tr> <tr> <td style="padding: 2px;">Waiver costs</td> <td style="text-align: right; padding: 2px;">\$ 98,629,504</td> </tr> <tr> <td style="padding: 2px;">Other Medicaid costs</td> <td style="text-align: right; padding: 2px;">\$ 57,187,192</td> </tr> </table>	People served by the Waiver	9,950	Waiver costs	\$ 98,629,504	Other Medicaid costs	\$ 57,187,192
People served by the Waiver	9,950						
Waiver costs	\$ 98,629,504						
Other Medicaid costs	\$ 57,187,192						
HISTORY	First approved in 1982 The next 5 year renewal is due January 2007. However, DMAS is currently working on changes that will likely be effective in 2005.						

MENTAL RETARDATION WAIVER

Fred's apartment is decorated with pictures and souvenirs from the many vacations he has taken in the past few years. He routinely walks to the neighborhood fast food restaurant to have breakfast with the other gentlemen who gather there most mornings. He works in a small office complex not far from his home. He gets to work using public transportation. He goes to bed when he wants. He goes into his kitchen when he wants. He has company when he wants. Fred would tell you he is living the good life.

For thirty years life had been very different. He ate, worked, slept, bathed when people told him to, where people told him to. He lived in an institution, an intermediate care facility. He did not like it but felt he had no choice. When he was a child, he was diagnosed as having mental retardation and placed in the institution. The institution was the only home he had ever known. The concept of choice was alien to him.

Home and community-based services became his choice. Fred was told about community services and asked if he wanted to stay in the facility or move into the community. He chose community. He moved to his own home.

Fred needed and wanted support to help him make the transition from the facility to his own apartment. The Community Services Board and local disability organizations provided support. Accessible, affordable housing was secured. Furniture was donated. A case manager with the Community Services Board met several times with Fred to explain home and community-based Mental Retardation services and how they could be used to support Fred in the community. In addition to having a place to live, Fred needed to learn how to maintain his household, how to maneuver through the community. Residential services were used to provide guidance to establish his household, plan meals, manage his budget, to do laundry. As time went on residential services were reduced. Personal care services were used to provide assistance with cooking, hygiene and household cleaning. Supported employment was needed initially until Fred was acclimated to his first paid job.

Last year, Fred learned about the new consumer-directed services available in the MR Waiver. His case manager explained how consumer-directed services were different from the traditional agency services. Fred chose to revise his Consumer Services Plan and change agency personal care to consumer-directed personal assistance services. The case manager provided Fred with a list of Consumer-Directed (CD) Facilitators. Fred chose a CD-Facilitator organization that he felt comfortable with. The CD-Facilitator provided information and training so that he would be able to hire his own attendants. The documents that are needed for consumer-directed services were audio taped so that Fred could access them at anytime. The CD-Facilitator is also available to answer questions or provide additional training. Fred hired individuals he knew to be his personal care attendants. This level of involvement in the process was a great self-esteem booster and assisted Fred in developing other independent living skills that he has used to expand his activities in the community.

Just like yours, Fred's life situation changes from time to time. Sometimes family or friends are supportive and sometimes he needs additional supports. His case manager is able to modify his services as the need arises. Fred has been reassured that the supports and services he needs to live safely in the community will be provided. He trusts his circle of family, friends and staff to listen to his desires, his needs and his choices. Fred knows he is now in control of his life.

Mental Retardation Waiver Services

Adult companion (8 hours maximum a day) (Consumer-directed & agency)
Assistive technology (\$5,000 maximum a year)
Crisis stabilization (60 days maximum a year)
Day support (780 units maximum a year of prevocational and supported employment units)
Environmental modifications (\$5,000 maximum a year)
Personal assistance (Consumer-directed & agency)
Personal Emergency Response System (PERS)
Prevocational services (780 units maximum a year of day support & supported employment)
Residential support (Congregate, group home or person's home)
Respite Care (720 hours maximum a year) (Consumer-directed & agency)
Skilled nursing services
Supported employment (780 units maximum a year of day support & prevocational units)
Therapeutic consultation

URGENT, NON-URGENT WAITING LIST AND PLANNING LIST

There are approximately 2,800 people on the MR Waiver waiting lists.

The urgent waiting list includes people who are eligible for the MR Waiver and meet the criteria listed below. The non-urgent waiting list includes people who are eligible for the MR Waiver but who do not meet the urgent criteria. The urgent and non-urgent waiting lists are maintained by the CSBs and DMAS. The planning list is maintained by the local CSB and includes people who may need MR Waiver services in the future.

CSBs determine placement on a waiting list, who receives the next available MR Waiver slot and must provide you with written notice if you are placed on a waiting list. Only after all people on the urgent waiting list are served will people on the non-urgent waiting list be provided the MR Waiver. People have the right to appeal the placement on a waiting list.

URGENT CRITERIA FOR THE MR WAIVER

- Primary caregiver(s) is/are 55 years or older, or
- Living with a primary caregiver who is providing services voluntarily and without pay and they can't continue care, or
- There is a clear risk of abuse, neglect, or exploitation, or
- Primary caregiver has a chronic or long term physical or psychiatric condition significantly limiting ability to provide care, or
- Person is aging out of a publicly funded residential placement or otherwise becoming homeless, or
- Person lives with the primary caregiver and there is a risk to the health or safety of the person, primary caregiver, or other person living in the home because the person's behavior presents a risk to himself or others OR physical care or medical needs cannot be managed by primary caregiver even with generic or specialized support arranged or provided by the CSB

MENTAL RETARDATION WAIVER

WHO	Persons up to age 6 who have a developmental delay and persons age 6 and older who have a diagnosis of mental retardation.						
FINANCIAL CONSIDERATIONS							
Monthly income limits	Up to 300% of SSI, \$1,692 per month maximum income in 2004						
Resource limits	Individuals can have up to \$2,000 of resources such as savings and bonds.						
When is financial eligibility determined?	By the local DSS once an individual has been approved for MR Waiver services. This process can take up to 45 days.						
Are there co-pay requirements?	Yes. If an individual has earned or unearned income above 100% of SSI, remaining amount is subject to a co-pay. If the individual is employed 8-20 hours per week, the individual can keep up to 200% of SSI before a co-pay is assessed. If the individual is employed 20 or more hours per week, the individual can keep up to 300% of SSI before a co-pay is assessed. In any situation, an individual's combined earned and unearned income cannot exceed 300% of SSI.						
Is a spend down available?	No						
SCREENING							
How is a screening initiated?	An individual or the individual's family/caregiver requests to be screened at his/her local Community Services Board.						
Who does an individual contact to begin the screening process?	The Community Services Board (CSB) is the single point of entry for mental retardation services.						
Who conducts the screening?	The Community Services Board (CSB)						
What is the screening criteria?	The same criteria used to evaluate an individual's eligibility for placement in an ICF-MR. The individual must meet two out of seven levels of functioning in order to qualify, in addition to the other requirements previously described.						
What survey is used to determine eligibility?	Level of Functioning Survey						
CASE MANAGEMENT	Case management is a State Plan service and is provided by CSBs.						
STATISTICS for Fiscal Year '03 July 2002-June 2003	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">People served by the Waiver</td> <td style="text-align: right;">5,496</td> </tr> <tr> <td>Waiver costs</td> <td style="text-align: right;">\$ 224,604,639</td> </tr> <tr> <td>Other Medicaid costs</td> <td style="text-align: right;">\$ 45,379,119</td> </tr> </table>	People served by the Waiver	5,496	Waiver costs	\$ 224,604,639	Other Medicaid costs	\$ 45,379,119
People served by the Waiver	5,496						
Waiver costs	\$ 224,604,639						
Other Medicaid costs	\$ 45,379,119						
HISTORY	First approved in 1991. The MR Waiver will be renewed in 2004.						

TECHNOLOGY ASSISTED WAIVER

The day of Sara's birth was exciting for her family. She was their first girl. Two older brothers were excited about the arrival of their new sister. Shortly after her birth, Sara began experiencing breathing difficulties that eventually resulted in the need for Sara to have a tracheotomy to assist her with breathing. As the weeks passed Sara was diagnosed with a variety of health and disability conditions that required her family to provide significant around the clock care. Sara's mother quit work in order to provide the level of care needed by her family. Sara's pediatrician encouraged her parents to contact the local community program for infants with disabilities. Sara's dad called the number and eventually learned about the services available to Sara and her parents through the Early Intervention Program. The Program referred Sara to a case manager at the local Community Services Board (CSB).

The CSB case manager explained Medicaid home and community-based Waiver services to Sara's parents. The case manager encouraged Sara's parents to request a screening for the Mental Retardation Waiver. Sara's dad explained that Sara did not have a diagnosis of mental retardation so he did not think she was eligible for the MR Waiver. He was also concerned that he might make too much money as a teacher to qualify for Medicaid. The case manager explained that children under the age of six did not need a diagnosis of MR to qualify for the MR Waiver and that financial eligibility for Waiver services was not determined based on the parents' income, only Sara's income would be considered. The case manager conducted a screening and determined that Sara was eligible for services in an intermediate care facility (ICF-MR). Immediately the case manager asked Sara's parents to select whether they wanted Sara to receive services in an ICF-MR or home and community-based services through the MR Waiver. This was a quick and easy decision for the family; they choose community services through the MR Waiver. A day or two went by and the case manager called the family and explained that there was a waiting list for services and unfortunately the CSB did not have an MR Waiver slot available for Sara. The case manager provided the family with information about how to appeal the denial of services and placement on the MR Waiver waiting list. The case manager explained that there was another home and community-based waiver that might meet Sara's needs, the Technology Assisted Waiver (Tech Waiver). The case manager gave the parents the name and telephone number for the health care coordinators with the Department of Medical Assistance Services (DMAS) in Richmond who is responsible for the Tech Waiver.

Sara's parents called the DMAS Tech Waiver health care coordinator who asked them some basic questions over the telephone and then mailed them a form to provide consent for the case manager to contact Sara's pediatrician and the CSB case manager. One of the first questions the DMAS health care coordinator asked was about Sara's insurance coverage. Sara's mom mailed a copy of their insurance policy to DMAS where staff reviewed the policy to determine if Sara would be eligible for Tech Waiver services. The DMAS coordinator determined that Sara would not be eligible for the Tech Waiver because the family's insurance policy covered some nursing services. DMAS told them that they could appeal this decision. The family decided to appeal the decision and seventy days later a hearing officer ruled that the private insurance policy was not a barrier to Sara accessing the Tech Waiver. A few days later, the Tech Waiver coordinator scheduled an appointment to come to Sara's home to screen Sara to determine if she would be eligible for the Tech Waiver. They asked many questions about the type of assistance Sara's family was providing to assist her with her health related needs such as care of the trach. At the conclusion of the coordinator's screening, Sara was determined eligible for services in a hospital setting. The coordinator asked the family to choose: hospital services or home and community-based services. The family selected home and community-based services through the Tech Waiver. That was three years ago.

Sara's life has dramatically improved since then. She receives ten hours a day of nursing services through the Tech Waiver. Her parents now have time to involve her in church activities and to spend time together in a relaxed home setting with all of the family. Sara has remained at home with her family. Last year Sara's grandmother who lives in Alabama became ill and Sara's mother had to go to Alabama to assist her mother. Sara's father is in the Navy and he was out at sea. Sara's mother was able to find friends to watch the children while she was going to be gone, but she could not find a nurse to volunteer to stay with Sara. The coordinator arranged for respite services to be provided by a nurse while both parents had to be temporarily away from home. Similar respite services have been provided for shorter periods of time so that Sara's parents can go out for the evening. The Tech Waiver has

provided some modifications to their home so that Sara, who uses a wheelchair, is able to safely maneuver in the bathroom and have access to her back yard. A lift was put in the family's van last year. The coordinator worked with the family and nursing agencies to arrange for nursing services to be provided for several days in Arizona when Sara went with her family to the Grand Canyon this summer.

Sara's school wanted to use her Medicaid nursing services during the school day. However, when the school realized that using those services during the school day would reduce the overall benefit available to Sara the school was not able to use those benefits. The Tech Waiver is one of only two home and community-based waiver programs in Virginia that has a limit on the cost of services to the person. Sara's parents and the school concluded that if Medicaid paid for services that Sara needed during the school day her services at home and in other community-based settings would have to be reduced. Thus, the school provides for the nursing services that are needed during the school day so that Sara is able to use her needed Medicaid nursing hours outside of school.

Sara is in the fourth grade, learning what all the other students are learning, she participates in activities with her peers. She attends church with her family. Her brothers tease and pester her, and she has learned to dish it right back. They love her, she loves them, and she loves being home.

Technology Assisted Waiver Services

Durable medical equipment not covered as State Plan services

Environmental modifications

Personal care (only for adults over 21 years of age)

Private duty nursing (16 hours maximum a day, except children may have 24 hours a day for the first 30 days after hospital discharge)

Respite care (360 hours maximum a year)

ELIGIBILITY CRITERIA UNIQUE TO THE TECH WAIVER

In addition to meeting the financial eligibility requirements, to be eligible for the Tech Waiver a person must also have the following needs:

- √ substantial and ongoing skilled nursing care, AND
- √ adults must depend part of the day on a vent or require prolonged intravenous nutrition, drugs or peritoneal dialysis
- √ children must depend part of the day on a vent; or require prolonged intravenous nutrition drugs or peritoneal dialysis; or have a daily dependency on other device-based respiratory or nutritional support

Private insurance can sometimes be a barrier to receiving Tech Waiver services. If your private insurance covers private duty nursing in your home, you might not be eligible for the Tech Waiver. If your private insurance only covers some of your nursing needs, the Tech Waiver may cover those private duty nursing hours that your private insurance does not cover. DMAS will review your private insurance policy and provide you with guidance about how your specific private insurance impacts your eligibility for the Tech Waiver. If you disagree with DMAS about their interpretation of your private insurance benefits you can appeal the DMAS decision that you are not eligible for the Tech Waiver.

TECHNOLOGY ASSISTED WAIVER

WHO	Individuals who are dependent upon technological support and require substantial, ongoing nursing care.						
FINANCIAL CONSIDERATIONS Monthly income limits Resource limits When is financial eligibility determined? Are there co-pay requirements? Is a spend down available?	Up to 300% of SSI, \$1,692 per month maximum income in 2004 Individuals can have up to \$2,000 of resources such as savings and bonds. By the local Department of Social Services after the individual has been determined to meet Waiver eligibility by the Nursing Home Pre-admission Screening Team. The eligibility determination process with the local Department of Social Services may take up to 45 days. Yes. If an individual has earned or unearned income above 100% of SSI, the remaining amount is subject to a co-pay. There are no earned income disregards in the Tech Waiver. Yes, this is determined by the local DSS during eligibility determination.						
SCREENING How is a screening initiated? Who does an individual contact to begin the screening process? Who conducts the screening? What is the screening criteria? What survey is used to determine eligibility?	An individual or family requests to be screened through the discharge planner at local hospitals, Department of Health or Social Services (local preadmission screening team) in the community, or an inquiry to DMAS. Home Care Coordinators (HCC) at DMAS at (804) 786-1465. For adults 21 years old and older, the local preadmission screening team completes a Virginia Uniform Assessment Instrument tool and sends it to a HCC at DMAS. The HCC conducts a home visit assessment using specialized care criteria. For children who are up to 21 years of age, the HCC at DMAS conducts the home visit assessment using the Technology Assisted Waiver assessment tool. There are two screening criterion that are considered to determine eligibility for the Tech Waiver. Functional Eligibility is determined by DMAS staff and is described above and Insurance Eligibility, which is determined by DMAS staff who review private insurance policies for Private Duty Nursing benefits that the recipient may or may not have Adults (21 years old and up): The Virginia Uniform Assessment Instrument tool and they must meet Nursing Home Specialized Care level of care. Children (Under 21): They must score 50 points or more on the Technology Assisted Waiver scoring tool.						
CASE MANAGEMENT	Case management is a part of the duties conducted by the Home Care Coordinators at DMAS, and is not a Waiver or SPO service.						
STATISTICS for Fiscal Year '03 July 2002-June 2003	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">People served by the Waiver</td> <td style="text-align: right;">337</td> </tr> <tr> <td>Waiver costs</td> <td style="text-align: right;">\$ 20,269,064</td> </tr> <tr> <td>Other Medicaid costs</td> <td style="text-align: right;">\$ 9,830,238</td> </tr> </table>	People served by the Waiver	337	Waiver costs	\$ 20,269,064	Other Medicaid costs	\$ 9,830,238
People served by the Waiver	337						
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HISTORY	The Tech Waiver was first approved by CMS in 1988 as the Ventilator Dependent Program. This was further modified to include children dependent on other technologies in the home. In 1997, adults were added to the Tech Waiver. DMAS is in the process of renewal for the Tech Waiver.						

MEDICAID WAIVER MENTORS

Contact these Mentors for information about Waivers or to schedule a workshop.

Tom Ambrose
Loudoun County CSB
Leesburg
703-777-0377
tambrose@loudoun.gov

Kathleen Babel
Equal Access
Luray
540-843-0414
kathleen-babel@excite.com

Janice Bailey
Richmond Goodwill Industries
Richmond
804-521-4934
jwbailey@goodwillrichmond.org

Lynne Blythe
Infant & Toddler Connection
Culpepper
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lblythe@rrcsb.org

Carol Brown
Commonwealth Autism Service
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Linda Carey
Resources for Independent
Living
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Becky Clark
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Sandra A. Cook
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397 Azalea Avenue
Richmond, VA 23227
804-371-3140
800-622-2155
www.vdbvi.org

Department for the Deaf and Hard of Hearing
VDDHH
Ratcliffe Building
1602 Rolling Hills Drive
Richmond, VA 23229
804-662-9502
800-552-7917
www.vddhh.org

Department of Health
1500 East Main Street
Richmond, VA 23219
804-371-0478
www.vdh.virginia.gov

Department of Medical Assistance Services
DMAS
600 East Broad Street
Richmond, VA 23219
804-786-1465
www.dmas.virginia.gov

**Department of Mental Health, Mental Retardation
and Substance Abuse Services**
DMHMRSAS
Jefferson Building
1220 Bank Street
Richmond, VA 23219
804-786-1747
www.dmhmrzas.state.va.us

Department of Rehabilitation Services
DRS
Lee Building
8004 Franklin Farms Drive
Richmond, VA 23229
804-662-7000
800-552-5019
www.vadrs.org

Department of Social Services
7 North Eighth Street
Richmond, VA 23219
804-726-7000
800-230-6977
www.dss.state.va.us

National Health Law Program
211 North Columbia Street
Chapel Hill, NC 27514
919-968-6308
www.healthlaw.org

Office of Comprehensive Services
CSA and FAPT
1604 Santa Rosa Road
Richmond, VA 23229
804-662-9815
www.csa.state.va.us

Statewide Independent Living Council
SILC
1720 Abbots Mill Way
Midlothian, VA 23114
804-897-8088
www.vasilc.org

Virginia Board for People with Disabilities
202 North Ninth Street
Richmond, VA 23219
804-786-0016
800-846-4464
www.vaboard.org

Virginia Office for Protection and Advocacy
VOPA
1910 Byrd Avenue
Richmond, VA 23230
804-225-2042
800-552-3962
www.vopa.state.va.us

Centers for Medicare and Medicaid Services
CMS
7500 Security Boulevard
Baltimore, MD 21244
410-786-3000
cms.hhs.gov www.hcbs.org

ACRONYMS

ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
AIDS	Acquired Immunodeficiency Syndrome
ARC	Aids Related Complex
ASO	Aids Service Organization
AT	Assistive Technology
BHA	Behavioral Health Authority
CD	Consumer-Directed
CD-PAS	Consumer-Directed Personal Assistance Services
CIL	Center for Independent Living
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)
CSA	Comprehensive Services Act
CSB	Community Services Board
CSP	Consumer Service Plan
DD	Developmental Disability
DMAS	Department Of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services
DRS	Department of Rehabilitative Services
DSS	Department of Social Services
E&D	Elderly and Disabled Waiver
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FAPT	Family Assessment and Planning Team
HCC	Home Care Coordinator
HCFA	Health Care Financing Administration (now CMS)
HIPP	Health Insurance Premium Payment
IADL	Instrumental Activities of Daily Living
ICF-MR	Intermediate Care Facility-Mental Retardation
IFDDSW	Individual and Family Developmental Disabilities Support Waiver
ISP	Individual Service Plan
LOF	Level of Functioning survey
MR	Mental Retardation
PAS	Personal Attendant Services
PERS	Personal Emergency Response System
POC	Plan of Care
SPO	State Plan Option (Medicaid services)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
UAI	Uniform Assessment Instrument
VBPD	Virginia Board for People with Disabilities
VDBVI	Virginia Department for the Blind and Visually Impaired
VDDHH	Virginia Department for the Deaf and Hard of Hearing
VOPA	Virginia Office for Protection and Advocacy

Alternative formats of this publication are available. Call 757-461-8007 in Tidewater or toll free 866-328-1088, or e-mail VaWaivers@endependence.org.