Customized Rate Provider Guide

Preface

Background

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

Over time, DBHDS has worked with community partners to define criteria that help to identify individuals whose support needs fall outside of the services offered in standard Waiver services. As a long-term solution to identified funding gaps that exist amongst this population, DBHDS, in partnership with the Department of Medical Assistance Services (DMAS), created the Customized Rate program.

Effective June 1, 2017, the Centers for Medicare and Medicaid Services (CMS) approved a Waiver amendment allowing DBHDS licensed providers to apply for a Customized Rate for individuals who meet qualifying criteria. Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs fall outside what the current rate structure provides and must meet certain criteria as described herein.

Customized Rates are funded directly through the Developmental Disabilities Waivers. These Waiver allow DBHDS to approve a modified rate, which replaces the standard rate for the individual's assigned level and tier. Upon approval, providers are required to submit a service authorization request for the specified service following all service authorization guidelines.

Forums

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

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

Guide Purpose

The purpose of the Customized Rate Provider Guide is to

provide practical and specific information to supplement the Waiver regulations and policy manual. Where possible, the Guide seeks to illustrate evolving best practices when applying for a Customized Rate and to clarify program rules and stipulations. The Guide:

- Provides a direct source for all information related to Customized Rates.
- Serves as a handbook regarding how to apply for a Customized Rate and outlines the process and criteria for approval.
- Clarifies and expands on the roles, responsibilities, and expectations of providers.

Guide Preparations & Updates

The original ***Guide***, published in July of 2017, was the result of cooperative efforts between DBHDS and DMAS who meet annually to discuss the program and content of the provider Guide. The Guide is created collaboratively by the Office of Waiver Network Supports of the DBHDS Division of Developmental Services and DMAS with input from a variety of sources. In 2021, DMAS began receiving recommendations and comments from community providers through the Town Hall public comment process. Hereafter, any changes to the Guide that have the potential to affect the overall program will be posted to the Town Hall for public comment. Every effort has been made to ensure content consistency in the Customized Rate Provider Guide.

Additional Resources

Providers can receive help and support with navigating the Customized Rate application in the Waiver Management System (WaMS) by locating the WaMS Customized Rates Application User Guide located in the Training Manuals, Webinars, and FAQs section of WaMS. This guide provides step-by-step instructions regarding WaMS navigation relating to application submission, uploading supplemental data, and responding to contingent approvals.

Guide Content

CUSTOMIZED RATE PROVIDER GUIDE

Effective 9/30/2024

PART I: DEFINITIONS

1.1-GENERAL DEFINITIONS

a) Customized Rate (CR) - A reimbursement rate that may be available to group home residential, sponsored residential, supported living residential, group day, community coaching and in-home support service providers that exceeds the normal rate applicable to the individual receiving these specific services.

b) Service Location-The location of the service:
- ROS=Rest of State
- NOVA=Northern Virginia

c) Supports Intensity Scale® (SIS) - an assessment tool and form that is published by the American Association on Intellectual and Developmental Disabilities and administered through a thorough interview process that measures and documents an individual's practical support requirements in personal, school-related or work-related, social, behavioral, and medical areas to suggest the types and intensity levels of the supports required by that individual to live a self-directed life in the community and to inform the discussion in the person-centered planning process; This tool is used to measure the individual's support needs resulting in a support needs level and reimbursement tier as follows:
- Level 1= Tier 1
- Level 2= Tier 2
- Levels 3-4= Tier 3
- Levels 5-7= Tier 4

d) Individual Support Plan (ISP) – Individual support plan" or "ISP" means a comprehensive, person-centered plan that sets out the supports and actions to be taken during the year by each provider, as detailed in each provider's plan for supports to achieve desired outcomes, and goals and dreams. The individual support plan shall be developed collaboratively by the individual, the individual's family/caregiver, as appropriate, providers, the support coordinator, and other interested parties chosen by the individual and shall contain the DMAS-approved ISP components

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

1.2-ROLE DEFINITIONS

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

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

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

d) Customized Rate Review Committee (CRRC) - The CRRC is a team of experts who provide input related to medical, behavioral, integrated supports, service authorization, and regional support services. The CRRC reviews all applicants regardless of support needs level and determines if a Customized Rate is approved.

1.3-FORM DEFINITIONS

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

b) Form SF-20- An Excel document that is required to be completed by all Customized Rate applicants which outlines the provider's staff salaries, licensed capacity, schedule of support, and credentials. This document can be located at: **https://www.dbhds.virginia.gov/developmental-services/Waiver-services.**
c) WaMS Customized Rates Application User Guide- A navigation guide that providers can refer to for help with navigating the Customized Rate application in WaMS.

1.4-SUPPORT/RATE DEFINITIONS

a) 1:1 Support - One staff assigned to the individual served whose sole responsibility is to support the individual based on their exceptional medical and/or behavioral support needs during the time 1:1 supports are approved.
b) 2:1 Support - Two staff assigned to the individual served whose sole responsibility is to support the individual based on their exceptional medical and/or behavioral support needs during the time 2:1 supports are approved.
c) Specialized Staffing - Direct support provided by professionals who have a higher level of expertise which is required to ensure proper support is given based on the individual's exceptional support need(s).
d) Programmatic Oversight – Oversight that is associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individual's exceptional support needs are carried out in a safe and effective manner. This supervision must be provided by staff with a higher level of expertise and whose expertise is not available through contracting for professionals which are Medicaid Waiver providers.
e) Fixed rate- A type of Customized Rate approval that is pre-determined and is approved based on demonstrated needs for either a higher level of staff credentialing or a higher staff-to-individual ratio of supports, or both being required.
f) Flexible rate- A type of Customized Rate approval that is individually determined and is variable, based on eligibility criteria such as the number of hours of increased staffing, increased level of Programmatic Oversight, and/or increased level of direct support credentialing required. The total supports combined replace the standard rate for the specified service.

PART 2: BASIC INFORMATION

Effective June 1, 2017, the Centers for Medicare, and Medicaid Services (CMS) approved a Waiver amendment allowing providers to apply for a Customized Rate for individuals who meet certain criteria as described herein. Providers are eligible to apply for a Customized Rate under the current Waiver system by accessing the Customized Rate application located in WaMS. If approved, a rate unique to the individual and/or service will be developed based on eligibility criteria and the individual's demonstrated need. Individuals eligible for a Customized Rate must have documentation to demonstrate that the complexity of their needs falls outside of the supports that are available and funded through the standard rate for their assigned reimbursement tier. Outliers to the current rate structure must meet certain criteria as described herein.

2.1-APPROVAL CRITERIA

A Customized Rate will be determined based on select criteria as described below:

- The individual has exceptional medical support needs that outweigh the resources available within the current Waiver rate structure.
  And/or
- The individual has exceptional behavioral support needs that outweigh the resources available within the current Waiver rate structure.
  and
- The individual requires 1:1 or 2:1 staffing support to ensure the health and safety of the individual and those around them.

2.2-QUALIFYING SERVICES

As a result, the individual may qualify for:

- Higher level staffing ratios of 1:1 or 2:1 to ensure the safety of the individual and others around them.

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

PART 3: ELIGIBILITY

Any provider supporting an individual on the Family & Individual Supports Waiver or Community Living Waiver is eligible to apply for a Customized Rate regardless of the individual's support needs level as determined by the Supports Intensity Scale and related processes.

3.1-ELIGIBLE WAIVERS & SERVICES

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

3.2-PROVIDER ELIGIBILITY CRITERIA

Providers should be able to demonstrate their ability to meet the individual's exceptional support needs through documentation of all that apply: staff training, employment of, or contract with a Registered Nurse, and/or involvement of a behavioral or psychological consultant or crisis team.

a) Providers should be able to demonstrate that they can meet the support needs of the individual through the employment of qualified staff trained to provide the extensive support required by the individual based on their exceptional support needs. Providers may qualify for Customized Rate reimbursement only when the provider's staff directly performs the support activities required by the individual for whom a Customized Rate is requested.
    - Providers must have training policies and procedures in place and demonstrate that staff has received appropriate training including, but not limited to, positive behavioral support strategies in order to support an individual with mental illness, behavioral challenges, or both.

b) All staff who will be supporting an individual, particularly those for whom the Customized Rate is being requested due to complex medical needs, shall receive individual-specific training from a Registered Nurse regarding the individual's medical condition(s), medication, risk factors, safety practices, procedures that staff are permitted to perform under nurse delegation, and any other training deemed necessary to enable the individual to be safely supported in the community. The provider shall arrange for the training to be provided by qualified professionals and document the training in the provider's record.

c) Providers supporting an individual via the Customized Rate due to the individual's behavioral support needs shall consult with a qualified behavioral specialist. A qualifying behavioral specialist must have one of the following credentials: LBA/BCBA, LABA/BCaBA, PBSF, Psychologist, LPC, LCSW, Psychiatrist, or Psychiatric Clinic Nurse Specialist. For more information regarding this requirement, reference 12VAC30-122-550. This qualified behavioral specialist shall develop a behavior plan based on the individual's needs and train the provider's staff in its implementation. Both the behavior plan and staff receipt of training shall be documented in the provider record.

d) Providers shall have on file a crisis stabilization plan for all qualifying individuals with complex behavioral needs. This plan shall include the direct interventions necessary to mitigate the risk of emergency

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

PART 4: DETERMINATIONS

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

a) Once an application is received in WaMS, the submitted information is reviewed by a Customized Rate Processor to ensure all essential information has been included. If it is determined by the Processor that additional information is required, the provider will receive a Form Note in WaMS alerting them of the need for additional information.
b) Form Notes are used as a communication modality between DBHDS and the provider regarding the Customized Rate request and are located within the application in WaMS. It is the provider's responsibility to check WaMS frequently and to respond to requests made by DBHDS in the Form Notes. Providers who have applications that are inactive in WaMS for longer than 30 days will be notified via Form Notes that the application will be denied.

4.1-VERIFICATION

All applications must go through a verification process by which a CRTC reviews and verifies that there is sufficient documentation to demonstrate that the provider has explored and exhausted all available resources prior to requesting a customized rate. This review is a higher-level review than what is completed by the processor and includes either a site visit, phone call, or virtual meeting. In some cases, individuals with an assessed support needs levels of 6-7 may, at the discretion of the CRTC, move directly to the committee without a verification interview.

a) Once an application is reviewed by the Processor and it is determined that all necessary supporting documentation has been included with the application, the application is forwarded to the CRTC who will contact the provider to conduct a preliminary assessment.
b) During the assessment, the CRTC will validate the information within the application, ensure that all front-line supports have been explored and/or accessed, and review supporting documentation related to the Customized Rate application.
c) Following the assessment, the CRTC will make a recommendation based on their findings to (1) move the application to the CRRC for review or (2) deny the Customized Rate. If the CRTC moves the application to the CRRC, a final review will be conducted, at which point it will be determined if a Customized Rate is approved.
d) If the CRTC determines that the application must be denied, an NOA letter will be emailed to the provider with an explanation of the denial. The NOA will be emailed to the staff member listed as the point of contact on the Customized Rate application.

4.2-COMMITTEE REVIEW

Once an application has been reviewed and determined that all necessary supporting documentation has been included with the application and, if applicable, a verification interview has been completed by the CRTC, the application is forwarded to the CRRC.

PART 5: SPECIALIZED STAFFING

Providers are expected to provide within the application, a written description of the staff's abilities to meet the needs of a qualifying individual and the training received related to such needs. Providers can request specialized staffing for any portion of their 1:1 or 2:1 support hours. To qualify for specialized staffing providers must meet ALL criteria in at least ONE of the listed approval levels (1-3).

5.1-SPECIALIZED STAFFING APPROVAL LEVELS

- **Approval Level 1**
  - A college degree
  - *Example: Associates in Human Services*
- **Approval Level 2**
  - Specialized licensing
  - *Example: Certified Nursing Assistant*
- **Approval Level 3**
  - Specialized training which is not typical of a standard Direct Support Professional
  - At least 5 years working with individuals identified as part of the target population
  - *Example: Medication Aide trained and 5 years' experience working with medically fragile individuals*

5.2-SPECIALIZED STAFFING: ADDITIONAL REQUIREMENTS

a) Providers are required to submit evidence that staff meet the outlined criteria by submitting official transcripts, credentials, resumes, or any other documents that indicate the level of combined education, training, and experience.
b) Support provided must be directly related to the individual's exceptional support needs
c) Providers may be asked to provide documentation related to the staff providing specialized support such as the record of payroll or provide a W-2.
d) Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service approved by the US Department of Education.
e) Qualifying degrees must meet the intent of a Human Services degree
   - {see list of Human Services and Related Fields Approved Degrees in section 6.4}

PART 6: PROGRAMMATIC OVERSIGHT

Programmatic oversight is oversight that is associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individual's exceptional support needs are carried out in a safe and effective manner. This supervision must be provided by staff with a higher level of expertise and whose expertise is not available through contracting for professionals which are Medicaid Waiver providers. Oversight which constitutes the practice of licensed professional services (e.g., nursing, behavior analysis) must be overseen by appropriately licensed/credentialed professionals performing duties within their scope of practice as indicated through their professional licensing/credentialing board.

6.1-PROGRAMMATIC OVERSIGHT - APPROVAL LEVELS

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

- **Approval Level 1**
  - Master's level degree
  - *Example: Master's degree in in Behavioral Science*
- **Approval Level 2**
  - Bachelor's level degree
  - Licensure in their specific area of expertise
  - *Example: Bachelor of Science in Nursing (BSN) and Registered Nursing license*
- **Approval Level 3**
  - Bachelor's level degree
  - Additional training that is directly related to the individuals exceptional support needs and is not a DBHDS required training.
  - At least 5 years working with individuals identified as part of the target population.
  - *Example: Bachelor's degree in Human Services, and training certification in Autism Spectrum Disorder and 5 years of experience working with individuals with Autism*

6.2-PROGRAMMATIC STAFFING: ADDITIONAL REQUIREMENTS

a) Support provided must be directly related to the individual's exceptional support need
b) Programmatic staff must be responsible for at least three or more of the Programmatic Oversight Approved Tasks and Responsibilities
    a. {See list of approved tasks and responsibilities in section 6.3}
c) Providers are required to submit evidence that staff meet the outlined criteria by submitting official transcripts, credentials, resumes, or any other documents that indicate the level of combined education, training, and experience.
d) Qualifying degrees must meet the intent of a Human Services degree
    a. {see list of Human Services and Related Fields Approved Degrees in section 6.4}
e) Providers are required to submit documentation related to the staff providing programmatic support and oversight such as proof of employment, record of payroll, or other forms of payroll verification.
f) If the employee is contracted, a copy of their contract must be provided- and include the duration of contractual assignments and agreed-upon compensation.
g) Qualifying degrees must have been awarded from among the schools listed on the U.S. Department of Education College Accreditation database (https://ope.ed.gov/dapip)
h) Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service approved by the US Department of Education.

6.3-PROGRAMMATIC OVERSIGHT: APPROVED TASKS AND RESPONSIBILITIES

Programmatic staff, as a part of their core responsibilities, must perform 6 or more of the following approved tasks and responsibilities to qualify:

1. Provide training to direct support staff (especially as it relates to changes in the ISP), which is evidence-based and/or evidence-driven, requiring adherence to support protocols.
2. Develop protocols and implement the processes that drive effective, safe, evidence-driven interventions/support plans, which result in outcomes that improve the daily life of the individual with high needs.
3. Oversee collection of medical or behavioral data to ensure proper implementation of protocols, including changing the protocols as needed as an individual navigates his or her environment successfully to achieve maintenance at a less intense level of staffing and resources, which results in a higher quality of engaged life with the community and family.
4. Serve as a liaison and provide expert opinion related to hospitalization and/or severe crisis interventions to ensure that protocols are maintained and/or amended as needed to reduce or prevent future hospitalizations, whether medical or behavioral; and, in cases of individuals with a history of or at risk of law enforcement involvement, ensure that officers and others are advised, trained, or connected such that risk of legal system involvement is avoided due to failure to provide adequate supports.
5. Oversee overall medical or behavioral operations to ensure that they are not only effective, but coordinated with external providers, Community Services Boards (CSBs), and emergency services and that protocols are clear regarding when and how to involve external providers.
6. Oversee individual supports to ensure all aspects of services which are prescribed and/or recommended by service area experts are delivered according to the individual's identified financial, medical, behavioral, social, and emotional support needs.
7. Coordinate and/or facilitate individual related meetings and appointments to include medical appointments, behavioral health, psychiatric services, and ISP meetings.
8. Provide overall management of program operations to include implementing agency policies and procedures, physical site management, financial procedures and budget, and compliance with human rights and licensing regulations.
9. Monitor staff performance, conduct staff evaluations, develop disciplinary plans of action, facilitate new hire processes including advertising and recruitment, and develop staff schedules to ensure staff that are qualified to support the unique needs of all individuals are employed.

10. Act as the primary point of contact providing individual and program-specific information to stakeholders such as families, guardians, state representatives, and CSBs and make critical decisions related to overall program operations.
11. Explore, request, and coordinate the use of supplemental funds and supports to ensure that all resources, to include natural resources and state/local funding, are maximized. This might include facilitating Waiver services, accessing REACH or other crisis services, managing Customized Rate funding requests or applying for local funding.

6.4: HUMAN SERVICES AND RELATED FIELDS, APPROVED DEGREES

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

PART 7: RATE INFORMATION

a) A Customized Rate is approved based on either a fixed rate or a flexible rate. Both the fixed rate and the flexible rate vary by region (Northern vs Rest of State).
b) Customized Rate funding cannot be requested for a specific dollar amount and does not cover the total cost of what a provider pays their direct support staff. Customized Rate funding first calculates the funding available for staffing in the standard rate model and takes into consideration the same assumptions as the standard rate model when calculating the costs of approved Customized Rate staffing.
c) Individuals who are approved for a Customized Rate for 24/7 residential support cannot receive personal assistant and/or companion services, skilled nursing, community coaching, community engagement or group day services during the time that a Customized Rate is authorized for 1:1 or 2:1 support. In no circumstance should these ancillary services be delivered/billed at the same time as residential supports are being delivered and reimbursed through the Customized Rate, as this is deemed double billing/duplicative service.

d) Providers are required to submit a schedule of support for the requested 1:1 or 2:1 support hours. DBHDS authorizes the provider to use an alternative schedule for 2:1 supports; however, either 1:1 or 2:1 staffing must be provided for the duration of the total authorized hours.

7.1-SPONSORED RESIDENTIAL

a) Customized Rate funding approved for Sponsored Residential Supports cannot be used to increase the sponsor payment directly.
b) Funding approved shall only be used to pay for and provide additional staff, not including the sponsor(s), who are necessary to provide the 1:1 or 2:1 support required to ensure the health and safety of the individual.
c) Families, caregivers, or other individuals who maintain full-time residential status in the home where the individual is receiving services, and who are not listed as a sponsored provider, can only be included in the Customized Rate request for additional 1:1 or 2:1 staffing if employment verification (W-2) is provided.
d) Families or caregivers acting as the sponsor are required to provide a minimum of 40 hours weekly of support to the individual before Customized Rate funding can be approved.
e) Eligible providers must indicate that they have met annual financial thresholds for paid staff, not including the sponsor, as shown below. Providers who are paying *less* than the outlined amount shown are ineligible for sponsored residential Customized Rate funding. The provider may be requested to provide financial records as verification.

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

7.2-RATE METHODOLOGY

a) In-home Supports

- Rate type: Fixed
- Allowable Supports:
  - 1:1 support with specialized staffing
  - 2:1 support with standard staffing
  - 2:1 support with specialized staffing with one standard staff and one specialized staff
  - 2:1 support with specialized staffing for both staff
- Rate range, ROS: $43.42 - $74.25/hr.
- Rate range, NOVA: $48.50 - $83.32/hr.
- Providers should ensure that they only bill the customized rate for the hours in which the approved staffing is provided. Otherwise, the standard rate should be billed.

b) Community Coaching

- Rate type: Fixed
- Allowable Supports:
  - 1:1 support with specialized staffing
  - 2:1 support with standard staffing
  - 2:1 support with specialized staffing with one standard staff and one specialized staff
  - 2:1 support with specialized staffing for both staff
- Rate range, ROS: $46.33 - $77.84/hr.
- Rate range, NOVA: $51.00 - $86.40/hr.
- Providers should ensure that they only bill the customized rate for the hours in which the approved staffing is provided. Otherwise, the standard rate should be billed

c) Group Day

- Rate type: Fixed
- Allowable Supports:
  - 1:1 support with standard staffing
  - 1:1 with specialized staffing
- Rate range, ROS: $39.03 - $42.69/hr.
- Rate range, NOVA: $44.49 - $48.69/hr.
- Providers should ensure that they only bill the customized rate for the hours in which the approved staffing is provided. Otherwise, the standard rate should be billed

d) Sponsored Residential, Group Home & Supported Living

- Rate type: Flexible
- Allowable Supports:
  - 1:1 support with standard staffing
  - 1:1 support with specialized staffing
  - 2:1 support with standard staffing
  - 2:1 support with specialized staffing with one standard staff and one specialized staff
  - 2:1 support with specialized staffing for both staff
  - Higher rate to provide Programmatic Oversight
- Rate range: Individually determined.
- The customized rate replaces the standard rate for the approved service

PART 8: APPLICATION & PROCESSING

A Customized Rate application must be submitted by the provider and can be accessed using WaMS. For technical support regarding navigation of WaMS, refer to the WaMS Customized Rates Application User Guide, which can be found in the 'Training Manuals, Webinars, and FAQs' section of WaMS.

a) To submit a Customized Rate application in WaMS, the individual must have:
   - A support needs level {Includes individuals placed in default level 2}
   - An active enrollment in a DD Waiver
   - An assigned Support Coordinator

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

PART 9: SUPPORTING DOCUMENTATION

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

Required	Explanation	Quantity
Behavioral Support Plan	Applicable to all individuals whose need for a Customized Rate is related to challenging behaviors. Behavioral plans must be written by a qualified behaviorist. A qualifying behaviorist must have one of the following credentials: LBA/BCBA, LABA/BCaBA, PBSF, Psychologist, LPC, LCSW, Psychiatrist, or Psychiatric Clinic Nurse Specialist. For more information regarding this requirement, reference 12VAC30-122-550. If a plan is not available, the provider is responsible for providing an explanation within the Customized Rate application, including the current status of obtaining behavioral support from a professional with the above-mentioned credential(s).	Current Active Plan

Behavioral Data	Applicable to all individuals whose need for a Customized Rate is related to challenging behaviors. Data should be submitted in such a way that the Customized Rate Committee can easily quantify the frequency, duration, and intensity of behaviors, preferably by the use of graphical data. Submission of daily notes is strongly discouraged; providers should make every attempt to submit data in an aggregated, quantifiable format. Examples: *Graphed behavioral data, crisis reports, history of psychiatric hospitalization, REACH referrals, quantifiable ABC data*	Past 6 months & supporting historical data
Health Supports Data	Applicable to all individuals whose need for a Customized Rate is related to high-level medical support needs and should include all protocols, medical orders, or data that substantiates the support needs listed in the application. Examples: *Medical reports, protocols, specialized supervision data, nursing care plan, seizure logs, Medication Administration Records, fall risk assessment, lift/transfer protocols, diabetic protocols*	Past 6 months & supporting historical data
Quarterly Reports	Quarterly reports should summarize the individual's overall status for the previous 3 months.	The 2 most recent quarterly reports
Staff Credentials	Applicable to all providers requesting Specialized Staffing and/or Programmatic Oversight and should include the credentials of the staff that will support the individual for whom a Customized Rate is requested. If scanned, documents must be a high-quality, clear scan. It is not necessary to submit credentials if specialized staffing and/or Programmatic Oversight are not requested. Examples: *A copy of licensure, college degree, official transcript, resume, signed contract (for contracted employees)*	Refer to submission criteria in sections 5-6
Payroll Verification	Applicable to all providers requesting Programmatic Oversight. Examples: *Paystubs with YTD total compensation, official payroll system compensation verification.* DBHDS reserves the right to ask for payroll verification for any staff listed on the customized rate application or FORM SF-20	Past 3 months
Overnight Support	Applicable to all providers requesting overnight support. Data must include awake/asleep patterns (times and duration) and also document the total intensity and duration of support needs throughout typical sleeping hours. DBHDS can provide example forms upon request.	Past 6 months
Form SF-20	Applicable to all providers. Form SF-20 documents the provider's staffing plan and is critical in the decision-making process. This form is located on the DBHDS website; additional instructions are provided within the document. ***Note:*** *Effective 1/1/2024 there will be an updated form which eliminates the requirement that providers submit a whole house budget. Staffing costs and verification will still be required. The updated form is located on the DBHDS website.*	Required with all initial and annual applications.
Incident Reports	Applicable to all providers. Incident reports should be submitted for any significant events related to the support needs of the individual as described in the application. This includes both reports from CHRIS, along with the provider's internal incident reports.	Past 6 months
Provider License	Applicable to all providers. Provider must upload a copy of their active DBHDS-issued license and license addendum (with all licensed locations listed).	Current Active License
Notice of Action Requirements	Applicable to provider applying for an annual customized rate or responding to a contingently approved customized rate. Provider must upload verification that all Notice of Action requirements have been adopted.	Required with all annual and

		contingent applications
1:1 or 2:1 staffing protocol	Applicable to all providers. Providers must upload a protocol outlining the specific duties of the staff providing 1:1 or 2:1, which should be individualized based on the person's needs as outlined in the Individualized Services Plan (ISP). DBHDS can provide example forms upon request.	Required with all initial and annual applications.
Additional Information	DBHDS may request additional information at any time to further justify or substantiate the request.	At the time of the request or anytime during the plan year

9.1-APPLICATION REVIEW

a) Form Notes/Request for Information - Form Notes are used to communicate with the provider in WaMS. It is the provider's responsibility to check WaMS frequently and to respond to requests made by DBHDS.

b) All correspondence made during the review process as outlined below are made between a member of the Customized Rate team and the point of contact listed in the application.
   - The provider point of contact listed on the application must be someone who can speak directly to the individual's day-to-day support needs and the information that was provided in the application. Providers listing a point of contact who is not familiar with the individual's direct support needs may experience a delay to the review process while discussions are rescheduled with a member of the provider's team who is able to effectively share the information being requested.

c) Once an application has been submitted, it will be reviewed by the Customized Rate Processor who ensures all required application areas are completed and supporting documentation is made available. The Customized Rate Processor will contact the provider's point of contact directly and schedule a call to discuss documentation requirements when applicable and confirm pertinent information regarding the individual's support needs.
   - Applications are reviewed in the order in which completed applications are received. Applications are not considered complete until all necessary supplemental documentation has been uploaded in WaMS and the application is submitted back to DBHDS.

d) Once the application has been processed, a CRTC is assigned to support the provider with the remainder of the customized rate process. The assigned CRTC is the primary liaison as it relates to the specific application.

e) The assigned CRTC will conduct a preliminary review of the application in preparation for presentation to the Customized Rate Review Committee. The preliminary review will be conducted either by phone, site visit, virtual meeting, or independently based on factors such as support needs level, previous NOA requirements, and other contributing factors.

f) After the completion of the CRTC preliminary review, the CRTC will notify the provider of the scheduled committee date/time. Providers must be available on standby via phone during the scheduled review to answer questions the committee members may have. If a call is placed and the point of contact is unavailable during the CRRC review meeting, the application will be moved to the next available CRRC meeting date.

g) The CRRC makes every attempt to meet no later than 30 calendar days after receipt of a completed application.

h) Providers who have applications that are inactive in WaMS for longer than 30 days will be notified via form notes that the application will be denied.

PART 10: APPROVALS

10.1-APPROVED APPLICATIONS

Approval is granted when the provider's data demonstrates the following:

a) The individual has exceptional medical and/or behavioral support needs;
And

b) The individual requires a staffing ratio of 1:1 or higher for the majority of their daily support needs;

And/or

c) The individual requires specialized staffing to safely and effectively provide direct support; And/or

d) The individual requires increased Programmatic Oversight in order to provide the required oversight and supervision of all key programmatic elements related to the individual's exceptional support needs.

10.2-NOTIFICATION

a) Notice of Action - Once a determination has been made by the CRRC, a Notice of Action (NOA) letter will be emailed to the provider's point of contact and the Support Coordinator listed in the application. Note that only the contact staff listed on the application will be notified. Providers who wish to have the NOA sent to other staff members should contact the processor. The NOA will provide detailed information regarding the recent review of the submitted Customized Rate application to include a description of the services approved. The reviewing committee may also make certain requirements or recommendations of the provider which will be documented in the NOA. These requirements may include mandatory training. The NOA will include:
   - Decision rendered (approved full-term, approved contingently, or denied)
   - Effective begin and end date
   - Customized rate dollar amount
   - Schedule of support (times in which the customized rate is approved)
   - NOA requirements: Action items that are necessary for approval at the time of the next annual review
   - Provider Agreement (see *Appendix A*)
   - All NOA's must be signed and uploaded to WaMS prior to approval of service authorizations

b) Following the email notification, providers will be contacted for an exit interview by the CRTC. During the exit interview, the CRTC will review the NOA in its entirety, to include:
   - The approval status, rate, and dates of approval
   - Review of any CRRC requirements made
   - Review of the provider agreement and requirements
   - Discussion of future site visits

10.3-DOCUMENTATION REQUIREMENTS

a) All providers who are approved for a Customized Rate must document throughout the plan year how the approved rate has been utilized to support the individual and submit documentation of such supports to include:
   - Evidence of 1:1 and/or 2:1 supports provided to include the frequency and duration of the support.
   - Evidence of the specific supports provided during 1:1 or 2:1 staffing.
   - Evidence of staff hired as a result of approved Customized Rate funding, to include credentials for staff approved to provide 'specialized' supports.
   - Evidence of programmatic supports provided.
   - Any additional action items as noted on the Notice of Action Letter

b) Providers who have been approved for Customized Rate funding must document in the individual's Plan for Supports how that provider will respond to the individual's specific exceptional needs, along with the individual's 1:1 and/or 2:1 specific support. Providers must update the Plan for Supports as necessary to reflect the current status of the individual. Providers must address each complex medical and behavioral support need of the individual through specific and documented protocols that may include, for example (i) employing additional staff to support the individual or (ii) securing additional professional support enhancements, or both, beyond those planned supports reimbursed through the standard rate for the specified service.

10.4-ANNUAL REQUIREMENTS

a) All providers who are approved for a Customized Rate must reapply annually in order to continue to receive Customized Rate funding. This is accomplished by submitting a new application and the associated supplemental documentation at least 30 days prior to the end of the individual's ISP. Providers who submit

their application after this date may incur a gap in Customized Rate funding during which time the standard rate for the specified service should be billed.

b) Providers must use WaMS to submit their annual application. On the service information page, use the drop-down menu to select, 'annual' {Refer to the WaMS Customized Rates Application User Guide for additional guidance}. Annual applications should be submitted with all of the required supplemental documentation that is required of an application.

c) The annual review date will be based on the individual's ISP year unless otherwise specified in the NOA, as with contingent approvals.

d) Additional information may be requested from the provider at the time of the annual review to determine if supports have been provided for the previous review period, and/or to determine the continued need for the Customized Rate. It is the provider's responsibility to ensure that proper documentation has been collected during the previous review period that indicates that the authorized supports have been provided.

e) The CRRC will often make recommendations and/or requirements to the provider or provide action steps (noted within the NOA) that must be adopted prior to the individual's annual review. Failure to provide evidence that these action steps have been explored and/or adopted at the time of the annual review can result in a denial of the annual request for a Customized Rate. Listed below are non-exhaustive examples of action steps providers might be required to adopt per the NOA:
   - Specific documentation requirements often related to how behavioral or medical supports are documented, measured, and analyzed.
   - Evidence of the exploration of other Waiver services.
   - Submission of medical and/or behavioral protocols.

f) Specific NOA requirements may be directed towards another service, such as Therapeutic Consultation. Requirements such as graphical data, formatting of data, ancillary provider plan revisions, etc. are the direct responsibility of the provider applying for the Customized Rate to obtain. Collaboration amongst the individual's service providers is imperative when applying for a Customized Rate.

g) Providers are responsible for responding to requests for additional information throughout the year.

h) Possible outcomes of an annual review: Based upon the submitted annual review application and supporting documentation, the committee can decide to:
   - Make no changes to the Customized Rate
   - Reduce the Customized Rate
   - Increase the Customized Rate
   - Terminate the Customized Rate

i) Providers are responsible for notifying DBHDS of any changes in the individual's support needs that would affect the continued need for a Customized Rate and/or result in the need for an adjustment to the Customized Rate. Lack of timely notification may result in the provider being in an overpayment status with DMAS. This includes:
   - Changes to support needs and daily schedule
   - Changes in support needs level/reimbursement tier
   - Individual discharge
   - Changes to approved specialized staffing
   - Changes to licensed bed capacity for residential services.

j) Providers must submit an 'annual' application as indicated in WaMS. If it has been more than one year since the last customized rate approval, the provider should submit an 'initial' application as indicated in WaMS.

k) DBHDS reserves the right to review an approved Customized Rate at any time throughout the year and make adjustments to the rate as deemed necessary.

l) Providers are required to participate in site visits conducted by a CRTC. DBHDS reserves the right to conduct unannounced site visits which may be conducted in collaboration with the Office of Human Rights and/or the Office of Licensing.

m) DBHDS reserves the right to end an authorized Customized Rate if the provider fails to render approved support, fails to document approved support, or based on findings during site visits.

10.5-CONTINGENT APPROVAL REQUIREMENTS

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

PART 11: SERVICE AUTHORIZATIONS

a) Approved Customized Rates replace the standard rate for the service approved for all flexible rate services [Group Home, Sponsored, Supported living]. Fixed rate services which are billed per hour [in-home support, group day, community coaching] should be billed based on the hours in which the provider is staffing the approved support.
    a. Providers approved for fixed rate services can bill both the standard rate and the customized rate, independently, so long as the hours of support do not overlap. The CRRC only approves the *rate* for fixed rate services, not the total *hours*. It is the provider's responsibility to only bill the customized rate for the hours necessary to safely support the individual. During all other times, the standard rate should be billed.
b) Approvals are retroactive to the date that a completed application was received and continues through the individual's ISP year unless otherwise noted in the NOA. The authorized start/end date of the Customized Rate will be noted on the NOA.
c) The effective start date will only be honored if the Service Authorization is submitted within 30 calendar days of the date listed on the top of the NOA
    a. Service Authorizations submitted after 30 days will be approved based on the date the Service Authorization is received by DBHDS.
    b. Service Authorizations cannot be submitted after the effective end date listed in the NOA. In this case the provider will need to reapply.
d) Once the NOA has been received, the provider is required to end the current service authorization and submit a new request using the associated Customized Rate service authorization code, unless submitting for in-home support with a combination of both standard and customized rate support needed.
    a. The NOA agreement must be signed and submitted with the Service Authorization request.
e) Regardless of the total Customized Rate approved, providers should ensure that they bill only for the support and service that they have utilized. Any potential overlaps in billing should be addressed in the Medicaid Enterprise System (MES) and/or directly with DMAS.
f) All service authorization questions or concerns should be addressed directly with the assigned Service Authorization Consultant.

11.1-SERVICE AUTHORIZATION CODES

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

11.2-FIXED RATE

a) For some services, the rate approved represents an approval for an increase on the base rate only (fixed rate). The total number of hours requested within each service should be submitted to Service Authorization for review and final approval.
b) The NOA outlines the approved hours of support. An increase or decrease in support hours throughout the plan year requires a notification to the Customized Rate team, at which time a revised NOA will be sent to the provider.
c) Fixed Rate Services which require additional approval from Service Authorization include:
    - In-Home Supports/ H2014 U1
    - Community Coaching/T2013
    - Group Day/ T2025

PART 12: DENIALS

a) Providers requesting a Customized Rate may be denied based on the following:
    - Exceptional support needs not demonstrated.
    - 1:1 or 2:1 staffing need not demonstrated.
    - Need for higher qualified staffing not demonstrated.
    - Need for increased Programmatic Oversight not demonstrated.
    - The Customized Rate Review Team determined that the requested service needs can be met within the individual's current level and tier or through the use of other services available to the individual within the Medicaid program.
    - Proper supporting documentation was not submitted, or an incomplete application was received.
b) Providers will be emailed an NOA letter, which will provide an explanation of the denial. Providers have the opportunity to discuss the details of the denials, along with any recommendations made by the CRRC, with the assigned CRTC following a denial.
c) Providers may reapply for a Customized Rate following a 30-day waiting period from the date of the NOA letter. A new application and updated supporting documentation are required. Additional person-centered data may be required with the new application and will be noted on the NOA letter.
d) It is important to note that a denial of the Customized Rate has no effect on the individual's ability to receive the standard rate for the specified service.

12.1-RIGHT TO APPEAL

a) DBHDS is required to inform providers of their right to appeal, based upon State and Federal codes (12 VAC [Virginia Administrative Code] 30-110-70 through 12 VAC 30-110-90) and Federal regulations (42 CFR [Code of Federal Regulations] 431). If you wish to appeal a denied Customized Rate, you must file a written notice of appeal with the DMAS Appeals Division within 30 days of the date on the NOA letter.
b) Customized Rate appeals are applicable to the provider only. Individual appeals are not accepted.
c) DBHDS does not govern the appeals process. For any questions regarding appeals, the provider should contact DMAS directly.

12.2-FILING AND APPEAL

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

- Through the Appeals Information Management System at https://www.dmas.virginia.gov/appeals/. From there you may fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You may download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/#appealsresources. You may use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The appeal must be received by the DMAS Appeals Division within 30 days of the receipt of this decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

12.3-APPEALS-NON-DISCRIMINATION

DMAS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This agency provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). This agency also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call us at (804) 786-7933 (TTY: 1-800-343-0634).

If you believe that this agency has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: Civil Rights Coordinator, DMAS, 600 E. Broad St., Richmond, VA 23219, Telephone: (804) 786-7933 (TTY: 1-800-343-0634).

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://hhs.gov/ocr/office/file/index.html.

12.4-APPEALS-HELP IN ANY LANGUAGE

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

Español (Spanish)

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

한국어 (Korean)

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

Tiếng Việt (Vietnamese)

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

繁體中文 (Chinese)

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

العربية (Arabic)

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

Tagalog (Tagalog – Filipino)

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

فارسی (Farsi)

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

አማርኛ (Amharic)

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

Urdu اردو

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

Français (French)

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

Русский (Russian)

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

हिंदी (Hindi)

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

Deutsch (German)

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

বাংলা (Bengali)

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

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa)

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

N'ihi na (Ibo)

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

èdè Yorùbá (Yoruba)

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

PART 13: GETTING HELP

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

- WaMS - Call the WaMS Help Desk for all “how-to” questions related to WaMS
    - Email: helpdesk@wamsvirginia.org {7:00 AM – 7:00 PM}
    - Phone: 844-4-VA-WaMS (844-482-9267)

- Providers should also refer to the WaMS Customized Rates Application User Guide located in the Training Manuals, Webinars, and FAQs section of WaMS.
- DD Service Authorization: (804) 663-7290
- DMAS Provider Helpline: (800) 552-8627 (in-state) or (804) 786-6273 (out-of-state)
- Customized Rate Inquiries and Assistance
  - Email: dbhdscustomizedrate@dbhds.virginia.gov
- Appeal Questions:
  - Mail-Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.
  - Email: appeals@dmas.virginia.gov; or
  - Fax: (804) 452-5454

APPENDIX A-PROVIDER AGREEMENT (NOA)

1. PROVISION OF FUNDING.

1.1. Approved funds must be requested through submission of a service authorization.

1.2. Service authorizations must be submitted within 30 calendar days of **DATE generated by WaMS**. Service authorizations submitted after 30 days will be approved based on the date that the service authorization was requested.

1.3. The provider is required to end the standard rate for the specified service prior to submission of a new service authorization.

1.4. The provider agrees and understands that 1:1 and/or 2:1 support approved cannot overlap with other ancillary Waiver services, i.e., companion services, nursing support, community coaching.

1.5. Ongoing consideration of funding is contingent upon submission of an annual application, supporting data and documentation verifying the previously approved support has been provided, the availability of current behavioral and/or medical data, and the provider's response to NOA requirements as outlined herein.

1.6. Failure to comply with the requirements set forth herein can result in a denial of funding and may result in reporting to licensing, human rights and/or DMAS as deemed necessary by DBHDS.

1.7. The provider agrees to provide the services as outlined in the schedule of support as follows:

Schedule of support inserted from WaMS

1.8. DBHDS authorizes the provider to use an alternative schedule for 2:1 supports, however either 1:1 or 2:1 staffing must be provided for the duration of the total authorized hours as outlined in section 7.7. Alternative schedules are not permitted for 1:1 service.

1.9. The provider agrees to utilize the following approved specialized and/or programmatic staff during the authorized time.

Staff approved for specialized staffing or program oversight from WaMS will be listed here

2. PROVIDER OBLIGATIONS.

2.1. The provider agrees that they have the tools, skills, abilities, and staff necessary to provide the outlined support as described within the customized rate application and approved herein.

2.2. The provider agrees to contract with or employ professionals critical to the individual's success, i.e., behavioral specialist, nurse, psychiatrist, support coordinator. These professionals should be actively supporting the delivery of customized rate supports as deemed necessary for documentation and analysis of the need for ongoing customized rate support.

2.3. The provider agrees to create and/or maintain record of all approved customized rate support and services, i.e., duration, frequency and intensity of support provided by direct support staff, program oversight staff,

or other professionals. This documentation must be submitted at least 30 days prior to the individual's ISP renewal date.

2.4. The provider agrees to comply with all NOA requirements set forth in section 5 of this Agreement.

2.5. The provider shall use funds only as specified in section 7 of this Agreement. Provider shall comply with all requests by DBHDS for information and documents related to the provision and use of services for which funding has been provided.

3. MODIFICATION.

3.1. Modifications to the amount or frequency of service for which customized rate funding as approved herein may only be approved by DBHDS after receipt of a written request from the provider. Changes to the rate are at the sole discretion of DBHDS.

3.2. No modifications to this Agreement shall be permitted to change or substitute the type of service provided. In that event, a new application shall be submitted.

3.3. The provider agrees to notify DBHDS in writing of any changes to the individual's support needs within 10 business days of the noted change, i.e., less 1:1 support is needed than what is currently authorized.

3.4. The provider agrees to notify DBHDS in writing of any changes to the individual's assessed support needs level within 10 business days of the noted change.

3.5. The provider agrees to notify DBHDS in writing of any changes to the licensed bed capacity for residential services within 10 business days of the noted change.

3.6. The provider agrees to notify DBHDS in writing of any changes to staff who are approved for specialized staffing or program oversight within 10 business days of the noted change.

4. SITE VISITS

4.1. DBHDS offers onsite technical assistance and support throughout the plan year which can be schedule at your convenience.

4.2. Site visits can occur anytime during the plan year. Please indicate if you would like a site visit during any point in the upcoming plan year.

☐**Yes, contact me regarding a site visit.**

☐**No, I don't need a site visit at this time.**

4.3. Providers may be asked to participate in unannounced or announced site visits at any time during the plan year.

IN WITNESS WHEREOF, Provider and DBHDS have executed this Agreement as of the effective begin date as noted in Section 4 herein. Failure to meet the terms of this agreement will result in denial of a customized rate. A signed copy of this agreement must be uploaded to WaMS prior to service authorization approval.

PROVIDER:

Signature: _____Printed Name: _____Date: _____

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES:

Signature: _____Printed Name: _____Date: _____