



# **Customized Rate Provider Guidelines**

(Updated 9.1.2019)

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## What is a Customized Rate?

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

➤ **A customized rate will be determined on select criteria as described below:**

- **The individual has exceptional medical support needs** that outweigh the resources available within the current waiver rate structure,  
**and/or**
- **The individual has exceptional behavioral support needs** that outweigh the resources available within the current waiver rate structure.

➤ **As a result, the individual may qualify for:**

- **Higher level staffing ratios** of 1:1 or 2:1 to ensure the safety of the individual and others around them.
- **Higher credentialed direct support staff (Specialized Staffing)** to ensure proper supports is given. This means that direct support professionals are required to have a higher level of expertise in order to provide specialized supports to the individual.
- **Increased programmatic costs** associated with the need for higher qualified supervision of direct support to ensure key programmatic elements related to the individuals exceptional support needs are carried out in a safe and effective manner. This supervision must be provided by staff with a higher level of expertise than routinely required by Qualified Developmental Disabilities Professional (QDDPs).

## What Services Are Eligible and Who Can Apply?

➤ **The following services are eligible for the customized rate:**

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

- ***Any provider supporting an individual on the Family & Individual Supports Waiver or Community Living Waiver are eligible to apply for the customized rate regardless of the individual's assessed SIS© score. However, provider's supporting an individual assessed to have support needs at SIS© levels 1-5 must be***

*verified by a Customized Rate Consultant (CRC) prior to review by the Customized Rate Review Committee (CRRC).*

### **How is a Customized Rate Determined?**

*It is the provider's responsibility to evidence through the customized rate application and supporting documentation that the applicant meets qualifying criteria. This includes clearly articulating the individual's support needs within the customized rate application, attaching all requested supporting documentation, and following all submission guidelines which will be further explained within this document. Providers who fail to properly demonstrate the individual's support needs, or who have not followed the submission guidelines may be denied a customized rate. The customized rate support team makes every attempt to work with providers to ensure sufficient information is submitted prior to a decision being made. Once an application is received, 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 be contacted and provided additional time to submit the requested information.*

#### ➤ **Committee Review**

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

#### ➤ **Verification (Level's 1-5)**

Applicants whose SIS© level falls within levels 1-5 must be verified by the CRC prior to review by the CRRC. Once an application is reviewed by the processor and determined that all necessary supporting documentation has been included with the application, the application is forwarded to the CRC who will contact the provider to either schedule a site visit or a phone conference. During the meeting the CRC will validate the information within the application, ensure that all front line supports have been explored and/or accessed and review supporting documentation related to the customized rate application. Following the meeting, the CRC will make a recommendation based on his/her findings to (1) move the application to the CRRC for review **or** (2) deny the customized rate. If the CRC moves the application to the CRRC, a final review will be conducted, at which point it will be determined if a customized rate is approved. If the CRC decides to deny the application, a Notice of Action (NOA) letter will be mailed to the provider with an explanation of denial.

### **Service Specific Rate Information**

#### ➤ **Rate Methodology: *There are two ways in which a rate is approved dependent upon the services requested:***

- A **fixed rate** is defined as a rate that has been pre-determined based on input from Burns & Associates, Inc. and is approved based on demonstrated need for either a higher level of staff credentialing or a higher staff to individual ratio of supports, or both being required.
- A **flexible rate** is defined as a rate that is individually determined and is variable based on eligibility criteria such as the number of hours of increased staffing, increased level of programmatic oversight, and/or increased level of direct support credentialing required.

- Both the fixed rate and the flexible rate vary by region (Northern vs. Rest of State).

- **In-home Supports (*Fixed Rate*)**, can be approved for the following:
  - Higher rate to provide 1:1 support with '*specialized staffing*'
  - Higher rate to provide 2:1 support with '*standard staffing*'
  - Higher rate to provide 2:1 support with '*specialized staffing*' for 2 staff
  - Higher rate to provide 2:1 support with '*specialized*' *staffing* for 1 staff
  - **Rate range: ROS: \$27.67 - \$47.00/hr.**
  - **Rate range: NOVA: \$32.56 - \$55.89/hr.**
- **Community Coaching(*Fixed Rate*)**, can be approved for the following:
  - Higher rate to provide 1:1 support with '*specialized staffing*'
  - Higher rate to provide 2:1 support with '*standard staffing*'
  - Higher rate to provide 2:1 support with '*specialized staffing*' for 2 staff
  - Higher rate to provide 2:1 support with '*specialized*' *staffing* for 1 staff
  - **Rate range: ROS: \$31.62 - \$55.28/hr.**
  - **Rate range: NOVA: \$36.07 - \$64.72/hr.**
- **Group Day (*Fixed Rate*)**, can be approved for the following:
  - Higher rate to provide 1:1 support with '*standard staffing*'
  - Higher rate to provide 1:1 with '*specialized staffing*'
  - **ROS: \$27.88 - \$30.35/hr.**
  - **NOVA: \$32.34 - \$35.48/hr.**
- **Sponsored Residential, Group Home & Supported Living (*Flexible Rate*)**, can be approved for the following:
  - Higher rate to provide additional hours of 1:1 support with '*standard staffing*'
  - Higher rate to provide additional hours of 1:1 support with '*specialized staffing*'
  - Higher rate to provide additional hours of 2:1 support with '*standard staffing*'
  - Higher rate to provide additional hours of 2:1 support with '*specialized staffing*' for 1 staff
  - Higher rate to provide additional hours of 2:1 support with '*specialized staffing*' for 2 staff
  - Higher rate to provide programmatic oversight
  - **Rate Individually determined**

### Specialized Staffing Qualifying Criteria

*Specialized staffing* is defined as **direct support** provided by professionals who have a higher level of expertise which is required to ensure proper supports is given based on the individual's exceptional support need.

- **To qualify for '*Specialized Staffing*' providers must meet ALL criteria in at least ONE of the listed approval levels (1-3)**
  - **Approval Level 1**
    - A college degree
    - Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service

Major studied must meet the intent of a Human Services degree (*see list of Human Services and Related Fields Approved Degrees on pages 8-9*)

Support provided must be directly related to the individual's exceptional support needs

**Example:** *Associates in Human Services*

▪ **Approval Level 2**

Specialized licensing/certifications

Support provided must be directly related to the individual's exceptional support needs

**Example:** *Certified Nursing Assistant*

▪ **Approval Level 3**

Specialized training which is not typical of a standard Direct Support Professional

At least 5 years working with individuals identified as part of the target population

Support provided must be directly related to the individual's exceptional support needs

**Example:** *Medication Aide trained and 5 years' experience working with medically fragile individuals*

**Program Oversight Approval Criteria**

**Programmatic oversight** is defined as **oversight** that is provided by highly qualified staff whose expertise is not available through contracting for professionals which are Medicaid waiver vendors. Qualifying programmatic staff must conduct three or more of the program oversight approved responsibilities (*See program oversight approved tasks/responsibilities on pages 7-8*). This support must be directly related to the individual's exceptional support needs.

➤ **To qualify for 'Program Oversight' providers must meet ALL criteria in at least ONE of the listed approval levels (1-3)**

▪ **Approval Level 1**

Master's level degree

Qualifying degrees must have been awarded from among the schools listed on the U.S. Department of Education College Accreditation database (<https://ope.ed.gov/dapip>)

Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service

Major studied must meet the intent of a Human Services degree (*see list of Human Services and Related Fields Approved Degrees on pages 8-9*)

Support provided must be directly related to the individual's exceptional support need

Programmatic staff must be responsible for at least 3 or more of the program oversight approved responsibilities

**Example:** *Master's degree in Behavioral Science*

▪ **Approval Level 2**

Bachelor's level degree

Licensure in their specific area of expertise

Qualifying degrees must have been awarded from among the schools listed on the U.S. Department of Education College Accreditation database (<https://ope.ed.gov/dapip>)

Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service

Major studied must meet the intent of a Human Services degree (*see list of Human Services and Related Fields Approved Degrees on pages 8-9*)

- Support provided must be directly related to the individual's exceptional support need
- Programmatic staff must be responsible for at least 3 or more of the program oversight approved responsibilities

*Example: Bachelor of Science in Nursing (BSN) and Registered Nursing license*

▪ **Approval Level 3**

- Bachelor's level degree
- Additional training related to the scope of responsibilities as identified within the program oversight approved tasks/responsibilities list
- At least 5 years working with individuals identified as part of the target population
- Qualifying degrees must have been awarded from among the schools listed on the U.S. Department of Education College Accreditation database (<https://ope.ed.gov/dapip>)
- Degrees obtained outside of the United States must be submitted with expert comparability recommendations prepared by a credentialing evaluation service
- Major studied must meet the intent of a Human Services degree (see list of Human Services and Related Fields Approved Degrees on pages 8-9)
- Support provided must be directly related to the individual's exceptional support need
- Programmatic staff must be responsible for at least 3 or more of the program oversight approved responsibilities

*Example: Bachelor's degree in Human Development, and training certification in Autism Spectrum Disorder for Paraprofessionals, and 5 years of experience working with individuals with Autism*

**Program Oversight: Approved Tasks/Responsibilities**

*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. Staff must conduct at least 3 tasks from the approved list of responsibilities.*

- **Training to direct support staff** (especially as it relates to changes in care plan), which is evidence-based and/or evidence driven requiring adherence to support protocols.
- **Development of protocols** and implementation of the processes that drive effective, safe, evidence-driven interventions/plans of care which result in outcomes that improve the daily life of the individual with high needs.
- **Oversight of medical or behavioral data** to assure proper implementation of protocols, including changing the protocols as needed as an individual navigates his or her environment successfully, to achieve maintenance at a less intense level of staffing and resources, which results in a higher quality of engaged life with the community and family.
- **Serve as a liaison and provide expert opinion related to hospitalization** and/or severe crisis interventions to ensure that protocols are maintained and/or amended as needed to reduce or prevent future hospitalizations, whether medical or behavioral; and in cases with individuals with a history of or at risk of law enforcement involvement, ensure that officers and others are advised, trained or connected such that an individual does not end up in the legal system due to failure of adequate supports.
- **Oversee overall medical or behavioral operations** to ensure that they are not only effective, but coordinated with external providers, Community Services Boards (CSBs), emergency services and that protocols are clear on when and how to involve external providers.

- **Oversee resident and/or program participant care** to ensure all aspects of services which are prescribed and/or recommended by service area experts are delivered according to the individual's identified financial, medical, behavioral, social, and emotional support need.
- **Oversee critical inventory** of all consumer medications, medical supplies, nutrition and personal items.
- **Coordinate and/or facilitate consumer related meetings** and appointments to include medical appointments, behavioral health, psychiatric services, and individual service plan meetings.
- **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.
- **Monitor staff performance**, conduct staff evaluations, develop disciplinary plans of actions, facilitate new hire process including advertising and recruitment and develop staff schedules to ensure staff that are qualified to support the unique needs of all consumers are employed.
- **Act as the primary point of contact** providing individual and program specific information to stakeholders such as families, guardians, state representatives, and community services boards and make critical decisions related to overall program operations.
- **Explores, requests and coordinates the use of supplemental funds and supports** to ensure that all resources, to include natural resources and state/local funding are maximized. This might include facilitation of Waiver services, accessing REACH or other crisis services, managing customized rate funding requests or applying for local funding.

#### 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
- Degrees not listed are reviewed individually

### Accessing the Application and Forms

*It is the provider's responsibility to clearly demonstrate that the individual for whom a customized rate is requested has exceptional support needs that outweigh the resources provided within the current rate structure by providing all of the requested supporting documentation, by completing the customized rate application accurately and responding to requests for additional information. Providers submitting applications that are incomplete or without proper supporting documentation attached can be denied a customized rate.*

- **Application** – An application to apply for a customized rate can be located on the DBHDS website: [www.dbhds.virginia.gov](http://www.dbhds.virginia.gov). In addition to the application, providers will be **required to submit the DBHDS Supplemental form (SFR-18 or SFD-18)**, also located on the DBHDS website.
  
- **Forms**
  - **Residential Forms**-should be used for the following services:
    - Group Home
    - Sponsored Residential
    - Supported living
    - The following **residential** forms are required:
      - **FORM RI-18**- The initial customized rate application
      - **FORM RA-18**-The annual customized rate application
      - **FORM-SFR-18**-This form replaces the former “staffing plan” template and is required with submission of all residential applicants, both initial and annual.
  
  - **Day Forms**- should be used for the following services:
    - Community Coaching
    - Group Day
    - In home residential
    - The following **day** forms are required:
      - **FORM DI-18**-The initial customized rate application
      - **FORM DA-18**-The annual customized rate application
      - **FORM SFD-18**-This form replaces the former “staffing plan” template and is required with submission of all day applicants, both initial and annual.

### Submission Guidelines

Providers should send a request to [dbhdscustomizedrate@dbhds.virginia.gov](mailto:dbhdscustomizedrate@dbhds.virginia.gov) for a secure email prior to application submission. DBHDS typically responds to these requests within the same day by sending a Virtru encrypted email. Once this secure email is received, applications should be submitted electronically to: [dbhdscustomizedrate@dbhds.virginia.gov](mailto:dbhdscustomizedrate@dbhds.virginia.gov) using the Virtru encryption service provided.

- **DBHDS cannot work with email encryption services outside of Virtru.** Should providers encounter a problem using Virtru; DBHDS will make every attempt to work with the provider to resolve the issue.
- If applying for more than one customized rate, the provider should submit two separate emails to DBHDS.
- **Information should be submitted in its original format,** e.g. word documents should be mailed in word format (\*.docx). Scanning all documents into a single file is not acceptable; submissions of this type will be sent back to the provider.
- **Faxed or mailed applications are not accepted.**
- Upon submission, the application will be validated by a customized rate processor to ensure all application requirements have been met. If additional information is required, the provider will be notified and given additional time to submit the requested information. **If the requested information is not received the customized rate may be withdrawn, or denied.**

### Supporting documentation

Providers are required to submit supplemental information which supports the customized rate request as described in the application. Please review the following requirements and ensure that all necessary information is submitted with the application.

| Supporting Documents Required       | Explanation  | Quantity/Time Frame                        |
|-------------------------------------|--|--|
| ISP Parts I through IV              | Providers submitting an annual application or those who have yet to accept an individual into their program can submit a draft copy  | Most Recent                                |
| Provider Plan for Supports (Part V) | Providers submitting an annual application or those who have yet to accept an individual into their program can submit a draft copy  | Most Recent                                |
| Behavioral Support Plan             | Applicable to all individuals who have challenging behaviors. If not available, the provider is responsible for providing an explanation within the customized rate application.   | Most Recent                                |
| Behavioral Data                     | Data should be submitted in such a way that the customized rate committee can easily quantify the frequency, duration and intensity of behaviors. Submission of daily notes is strongly discouraged; providers should make every attempt to submit | Past 6 months & supporting historical data |

|                        |   |  |
|------------------------|---|--|
|                        | <p>data that can be quantified.</p> <p>Examples: <i>Graphed behavioral data, crisis reports, history of psychiatric hospitalization, REACH referrals</i></p>  |  |
| Health Supports Data   | <p>Protocols and orders should be submitted to substantiate all support needs listed in the application.</p> <p>Examples: <i>Medical reports, protocols, specialized supervision data, nursing care plan, seizure logs, Medication Administration Records, fall risk assessment, lift/transfer protocols, diabetic protocols</i></p>  | Past 6 months & supporting historical data                 |
| Quarterly Report       | <p>Quarterly report should summarize the individual's overall accomplishment for the previous 3 months.</p>   | The 2 most recent quarterly reports                        |
| Staff Credentials      | <p>All providers requesting 'specialized' staffing <b>or</b> 'program oversight' are required to submit the credentials of the staff that will support the individual for whom a customized rate is requested. Please refer to the criteria for the service requested. If scanned, documents must be a high quality, clear scan. It is not necessary to submit credentials if specialized staffing and/or program oversight are not requested.</p> <p>Examples: <i>A copy of the staff license, college degree, or official transcript.</i></p> | Refer to submission criteria (pg. 6-7)                     |
| Crisis Plan            | <p>Where applicable</p>   | Most recent  |
| Overnight Supports     | <p>If requesting oversight supports, the provider must submit data which indicates that the individual is (1) awake frequently during the night and/or (2) supporting information which indicates the type and frequency of supports provided during the overnight hours.</p>   | Past 6 months  |
| Form SFR18 or SFD18    | <p>This form is located on the DBHDS website and is critical in the decision making process. Instructions are provided within the document.</p>   | Required with initial and annual applicants                |
| Additional Information | <p>DBHDS may request additional information at any time to further justify or substantiate the request.</p>   | At the time of the request or anytime during the plan year |

### What Happens After The Application is Submitted?

*Once it is determined that all necessary information has been provided to substantiate the application, the provider will be contacted and provided the date that a CRRC meeting has been scheduled. Most often, CRRC meetings occur on Wednesday of each week between the hours of 9:00am and 12:00pm. The provider will be **requested to be available (by phone) during this time** in the event that the team has additional questions as it*

relates to the request. The provider representative must be someone who can speak directly to the individual's support needs and the information which was provided in the application. The committee will only call if there are additional questions that cannot be ascertained within the provided documentation. **Applicants who are unavailable during the CRRC will be moved to the next available CRRC meeting date.**

- The CRRC makes every attempt to meet no later than 15 business days of receipt of a completed application; **providers submitting for an individual falling in levels 1-5 will incur a longer waiting period based on the CRC review which must occur prior to the CRRC meeting.**
- Applications are reviewed in the order in which they are received.

### Approval

- **The approval criteria requires that the submitting provider has provided sufficient documentation to evidence that:**
  - The individual has exceptional medical and/or behavioral support needs;  
**And**
  - Requires a staffing ratio of 1:1 or higher for the majority of their daily support needs;  
**And/or**
  - The individual requires specialized staffing to safely and effectively provide direct supports;  
**And/or**
  - The individual requires increased programmatic oversight in order to provide the required oversight and supervision of all key programmatic elements related to the individual's exceptional support needs and the individual's exceptional support needs require staff with higher credentials than are routine for a Qualified Developmental Disabilities Professional (QDDP)
- If a customized rate has been approved by the CRRC, ***a Notice of Action (NOA) letter will be mailed to the provider.*** 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 CRRC will often make recommendations to the provider, or provide action steps (noted within the NOA) which **must be adopted prior to the individual's annual review.** Failure to provide evidence that these actions steps and/or recommendations have been explored and/or adopted at the time of the annual review can result in a denial of the annual request for a customized rate. **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.**
- **All providers who are approved for a customized rate must document throughout the plan year how the approved services have been utilized to support the individual and submit documentation of such supports to include:**
  - Evidence of 1:1 and/or 2:1 supports provided to include the frequency and duration of the support.
  - Evidence of the specific supports provided during 1:1 or 2:1 care.
  - Evidence of staff hired as a result of the customized rate to include credentials for staff approved to

provide 'specialized' supports.

- Evidence of programmatic supports provided.

➤ **If additional information beyond what is noted above is requested within the NOA, detailed instructions will be included in the NOA, along with the date that this information is requested by. Listed below are examples of what some providers might expect to see:**

- Specific documentation mandates made by the CRRC, often related to behavioral or medical support needs
- Request for a new Supports Intensity Scale® (SIS®) assessment
- Evidence of the exploration of other Waiver services

➤ Approved customized rates **replace the standard rate** for the service approved.

➤ Approvals are **retroactive to the date of a completed** application received and continue through the individual's plan year; this date will be noted on the NOA.

➤ Once the NOA has been received, the provider is required to **end the current service authorization and submit a new request** using the associated service authorization codes. A copy of the NOA should be attached to the service authorization request.

### Service Authorization Codes

| Service                                    | Service Authorization Code |
|--|----------------------------|
| Community Coaching/Customized Rate         | 97127 U1                   |
| Group Day Support Services/Customized Rate | T2025                      |
| Group Home/Customized Rate                 | T2016                      |
| In-Home Support Services/Customized Rate   | H2014 U1                   |
| Supported Living/Customized Rate           | H0043 U1                   |
| Sponsored Residential/Customized Rate      | T2033 U1                   |

➤ **For the following services, Customized Rate approval represents an approval for an increase on the base rate only.** The total number of hours requested within each service should be submitted to Service Authorization for review and final approval. In example, individuals approved for community coaching supports with 1:1 standard staffing, living outside of the Northern Virginia area will receive a rate of \$47.77. However, the total number of hours requested at this rate must be submitted to Service Authorization for review and final approval.

- In-Home Supports/ H2014 U1

- Community Coaching/97127 U1
- Group Day/ T2025

- The provider must **reapply annually for the customized rate** by submitting a new application and the associated supplemental documentation at least 30 days prior to the end of the individual’s ISP.
- **In some cases the customized rate is approved for a time period of less than the full ISP year** (Contingent Approval). In these circumstances the provider will be made aware of the slated end date within the NOA.
  - Contingent approvals are typically approved for less than the full ISP year to allow the provider additional time to collect data necessary for a full approval.
  - The provider is not required to submit a new application for contingent approvals. The NOA will outline what information is necessary for a full approval and provide a deadline for submission.
  - Providers who fail to submit the requested information by the slated end date 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.
  - Providers who fail to submit the requested information within 60 days of the end date will be withdrawn and are required to complete a new application if a continued customized rate is needed.
- **For assistance with authorization of the customized rate or WaMS please refer to the following contacts:**

| Helpline Contact                      | Phone / E-mail |
|---------------------------------------|----------------|
| WaMS                                  | (844) 482-9267 |
| DD Service Authorization              | (804) 663-7290 |
| DMAS Provider Helpline                | (800) 552-8627 |
| Customized Rate ( Rate specific Info) | (804) 774-4472 |

- **DBHDS reserves the right to review an approved customized rate at any time throughout the year and make adjustments to the rate as deemed necessary.**
- **Providers are responsible for notifying DBHDS of any changes in the individuals support needs** that would affect the continued need for a customized rate and/or result in the need in an adjustment to the customized rate. This includes changes to support needs, changes in SIS© levels, and changes to bed capacity for residential services.
- **Providers are responsible for responding to requests for additional information throughout the year** and at random may be asked to participate in an onsite visit with the CRRC or designees.

**Denial**

- **Application Denied-**
  - Providers requesting a customized rate for an individual can be denied based on the following:

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

➤ **Providers will be mailed via standard mail a NOA which will provide an explanation of denial.**

➤ **Providers are able to reapply for a customized rate following a 30 day waiting period** if additional information is available to substantiate the request, or if the individual's support needs have changed since the last review. A new application and updated supporting documentation is required.

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

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

### **Annual Reviews**

*It is the provider's responsibility to submit an annual application at least 30 days prior to the end of the individual's plan year. DBHDS will make every attempt to send a reminder request for an updated application and supporting documentation 60 days prior to the annual review date.*

➤ **The annual review date will be based on the individual's service plan year.**

➤ **It is the Providers responsibility to provide supporting documentation and an updated application** indicating the need for a continued customized rate. Providers who fail to submit the requested information will not be authorized for a customized rate for the following plan year.

➤ **Additional information may be requested from the provider at the annual review** to determine if supports have been provided for the previous review period, and/or to determine the continued need of the customized rate.

- **It is the provider's responsibility to ensure that proper documentation has occurred** during the previous review period that indicates that the supports approved under the customized rate have been utilized to include 1:1, 2:1 and programmatic oversight.
- **Providers may be asked to adopt certain recommendations prior to resubmitting their annual application.** These recommendations will be made in the NOA letter which is mailed to the provider at the time of the initial approval.
- **The information that will be required for annual reviews is as follows:**  
Providers submitting an annual application must complete a new application and follow all previously outlined tasks associated with initial applications. This includes submitting updated supporting documentation, staff credentials, Form SFR-18/SFD-18, and for providing information to validate that the services approved under the customized rate have been provided.
- **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

## Frequently Asked Questions

### **1. How do I ensure privacy when submitting a customized rate application?**

DBHDS uses Virtru to ensure information is secure when sending. If you are unfamiliar with this service or not registered, you can email: [dbhdscustomizedrate@dbhds.virginia.gov](mailto:dbhdscustomizedrate@dbhds.virginia.gov) and request a secure email. Once received, you will be prompted to register with Virtru.

### **2. I use a different secure email server; can I use this service to submit my application?**

Unfortunately, we do not accept emails from other servers; however, if you are having difficulty submitting information, please contact us and we will work with you to solve the problem.

### **3. I am accepting a new individual into my service that already is approved for a customized rate with another provider. Do I still need to complete a new customized rate application?**

Yes, customized rates are approved based on the provider submitted application. Therefore, if the individual is new to your service/home you should submit a new, initial application.

### **4. What application should I use?**

Residential applications (Form RI-18) should be used for the following services: Group Home, Sponsored Residential, and Supported Living. Day applications (Form DI-18) should be used for the following services: Community Coaching, Group Day and In-home Supports. If the individual is already approved

for a customized rate an annual application should be used: Residential-Annual (Form RA-18), or Day-Annual (Form DA-18). Additional information can be found by reviewing the Provider Information-Forms notice located on our website.

**5. Approximately how long does the approval process take once the application is received?**

Applications are reviewed based on the order in which they are received and typically take less than 30 days from the time a completed application is received. Applicants are processed differently based on the individual's assigned SIS© level. Those falling in SIS© levels 1-5 must be reviewed by a CRC prior to being reviewed by the CRRC. This process can take 3-4 weeks in total and typically includes an onsite review. Individuals who fall in SIS© level 6-7 go directly to the committee for review and typically take less time. It is important to note that applications cannot be reviewed by the CRC or the CRRC until a completed application is submitted. As such, it is important to review the provider guidelines located on our website and ensure that applications are submitted with all required supporting data and supplemental documents. Applications that are pended due to missing information can take an extended period of time and are closed by DBHDS after 30 days of inactivity.

**6. Can we submit a customized rate application for the specified amount of funding that we plan to pay our direct support staff based on the high intensity support needs of the individual?**

No, customized rates cannot be requested for a specific dollar amount and are not approved based on the funding need of the provider. Rather, customized rates are approved based on the demonstrated support needs of the individual. However, providers who employ staff meeting criteria outlined in the provider guidelines (See Specialized Staffing) are often approved at a higher rate for 1:1 and 2:1 support hours based on the intensity of the individual's support needs.

**7. Can we request compensation for a manager/supervisor to manage staffing patterns and staff?**

Although the customized rate cannot be requested for a specific dollar amount, it is possible that some of the costs associated with employing high level programmatic staff are included within the approved customized daily rate. To qualify, providers must demonstrate that the employed programmatic staff meets minimum qualifications as outlined in the provider guidelines.

**8. Does the application process for customized rates consider approval of funding for a van, electronic devices, employee training or environmental modifications?**

No, customized rates are strictly based on the individual's support need, e.g., increased staffing supports, a need for higher qualified staff to provide support, and/or, a need for high level programmatic staff. The customized rate does not consider or cover the costs of any environmental modifications, equipment, cost of living, or business related costs.

**9. Does the customized rate replace the current rate, or is it approved in addition to the standard rate for the approved service?**

The customized rate replaces the current rate for the approved service. When requesting a service authorization for the approved customized rate, providers should end the service authorization for the standard rate for the requested service and submit a new request for the approved customized rate.

**10. How will I know if my customized rate application was approved?**

Once a decision has been made a notice is mailed to the provider within 5-7 business days. The notice of action (NOA) will detail the committee decision and if approved, the rate approved, the number of 1:1/2:1 hours approved, the effective begin/end date, and will also include recommendations which may be required to be implemented prior to the annual renewal.

**11. An individual new to my service might need a customized rate but I don't have any current data. Can I still apply?**

Yes, although it is recommended that an individual is served within the service for at least 3 months prior to applying for a customized rate; the customized rate committee understands that this may not always be the best option. Individuals who are new to your service or who have not yet been accepted into the service can still apply for a customized rate however, providers will need to contact the CSB Support Coordinator, family, and previous providers to collect historical data and submit as much information as possible such that the committee can clearly understand the individual's support needs. Most often, individuals who do not have sufficient data at the time of approval are approved for a contingent 3-6 month period allowing the provider additional time to collect and submit data required for a full term approval.

**12. An individual that I serve is currently receiving a customized rate and recently received a change in their SIS© score. Will this affect my rate?**

Possibly. Providers are required to report any changes in the individual's status that might result in change to the standard rate. This includes changes in bed capacity for group home services and changes in the individual's SIS© score. However, not all SIS© score changes will result in a change to the customized rate.

**13. I was denied a customized rate, what are my options?**

Providers who were denied a customized rate have two options, (1) reapply following a 30 day waiting period and provide additional information which was not provided previously to support the application and need, or (2) appeal the rate within 30 days to the Department of Medical Assistance Services (DMAS).

**14. Where can I find out more about customized rates?**

All customized rate forms and guidance documents can be located by visiting our webpage at: <http://www.dbhds.virginia.gov/developmental-services/waiver-services>

**15. I still have questions, who should I contact?**

You can submit your questions to [dbhdscustomizedrate@dbhds.virginia.gov](mailto:dbhdscustomizedrate@dbhds.virginia.gov) or contact Carrie Ottoson at: 804-774-4472