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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **MARY-GRACE MENDOZA**
Assistant Attorney General

DATE: **November 1, 2013**

SUBJECT: **Final Stage Action - Technology Assisted Waiver Update (12 VAC 30 -120-70 through 30-120-120 REPEALED; 12 VAC 30-120-1700 *et. seq.*)**

This memorandum responds to your request that this Office review the final stage action that repeals the existing Technology Assisted Waiver regulations (12 VAC 30-120-70 through 12 VAC 30-120-120) and promulgates new regulations at 12 VAC 30-120-1700 *et seq*. The purpose of this regulatory action is to achieve greater consistency and clarity in content and format with other DMAS waiver programs.

Based on my review, it is this Office's view that DMAS has the authority, subject to compliance with the provisions of Article 2 of the Administrative Process Act (APA), and has not exceeded that authority.

Va. Code §§ 32.1-324 and 32.1-325 grant to the Board of Medical Assistance Services the authority to administer and amend the plan for Medical Assistance and authorizes the Director of DMAS to administer and amend the plan for Medical Assistance according to the Board's requirements. The authority for these proposed regulations derives from the Social Security Act, *see* 42 U.S.C.S. § 1396(n).

Please call me at (804) 786-6004 if you have any questions regarding this memorandum. Thank you.

cc: Kim F. Piner
Chief/Senior Assistant Attorney General

Final Text

Action: Technology Assisted Waiver Update

Stage: Final 10/3/13 1:38 PM [latest]

12VAC30-120-70

12VAC30-120-70. ~~Definitions~~. (Repealed.)

~~The following words and terms, when used in this part, shall have the following meanings unless the context clearly indicates otherwise:~~

~~"Activities of daily living (ADL)" means personal care tasks, i.e., bathing, dressing, toileting, transferring, bowel/bladder control, and eating/feeding. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services.~~

~~"Adult" means an individual who either is 21 years of age or is past 21 years of age.~~

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

~~"Child" means an individual who has not yet reached his 21st birthday.~~

~~"Congregate living arrangement" means one in which two or more recipients live in the same household and may share receipt of health care services from the same provider or providers.~~

~~"Congregate private duty nursing" means nursing provided to two or more recipients in a group setting.~~

~~"DMAS" means the Department of Medical Assistance Services.~~

~~"Environmental modifications" means physical adaptations to a house, or place of residence, which shall be necessary to ensure the individual's health or safety, or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual. Such modifications must exceed reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 1201 et seq.).~~

~~"Health care coordination" means a comprehensive needs assessment, determination of cost effectiveness, and the coordination of the service efforts of multiple providers in order to avoid duplication of services and to ensure the individual's access to and receipt of needed services.~~

~~"Health care coordinator" means the registered nurse who is responsible for ensuring that the assessment, care planning, monitoring, and review activities as required by DMAS are accomplished. This individual may be either an employee of DMAS or a DMAS contractor.~~

~~"Instrumental activities of daily living (IADL)" means social tasks, i.e., meal preparation, shopping, housekeeping, laundry, money management. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services. The provision of IADLs is limited to the individual receiving services and not to family members or other persons in the household. Meal preparation is planning, preparing, cooking and serving food. Shopping is getting to and from the store, obtaining/paying for groceries and carrying them home. Housekeeping is dusting, washing dishes, making beds, vacuuming, cleaning floors, and cleaning kitchen/bathroom. Laundry is washing/drying clothes. Money management is paying bills, writing checks, handling cash transactions, and making change.~~

~~"Medical equipment and supplies" means those articles prescribed by the attending physician, generally recognized by the medical community as serving a diagnostic or therapeutic purpose and as being a medically necessary element of the home care plan. Items covered are medically necessary equipment and supplies needed to assist the individual in the home environment, without regard to whether those items are covered by the Plan.~~

~~"Objective Scoring Criteria" means the evaluative tool to be used to determine the appropriateness for an individual's admission to these services.~~

~~"Personal assistance" means care provided by an aide or respiratory therapist trained in the provision of assistance with ADLs or IADLs.~~

~~"Personal emergency response systems" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. 12VAC30-120-970 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

~~"Plan of care" means the written plan of services and supplies certified by the attending physician needed by the individual to ensure optimal health and safety for an extended period of time.~~

~~"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for such care.~~

~~"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.~~

~~"Providers" means those individuals or facilities registered, licensed, or certified, or both, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.~~

~~"Respite care services" means temporary skilled nursing services designed to relieve the family of the care of the technology assisted individual for a short period or periods of time (a maximum of 15 days per year or 360 hours per 12-month period). In a congregate living arrangement, this same limit shall apply per household. Respite care shall be provided in the home of the individual's family or caretaker.~~

~~"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.~~

~~"Technology-assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability and whose illness or disability would, in the absence of services approved under this waiver, require admission to or prolonged stay in a hospital, nursing facility, or other medical long-term care facility.~~

~~"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

12VAC30-120-80
12VAC30-120-80. ~~General coverage and requirements for technology assisted waiver services.~~ (Repealed.)

~~A. Coverage statement.~~

~~1. Coverage shall be provided under the administration of DMAS for certain technology assisted individuals who would otherwise remain in hospitals (for individuals under 21) or specialized care nursing facilities (for those over 21) for which Medicaid reimbursement would be made.~~

~~2. The objective of this waiver is to provide for medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community.~~

~~3. Coverage shall not be provided for these services for individuals who reside in board and care facilities or adult care residences nor who are inpatients in general acute care hospitals, skilled or intermediate nursing facilities, or intermediate care facilities for the mentally retarded.~~

~~B. Patient qualifications. A Medicaid eligible technology assisted individual shall be eligible for services if he meets the following requirements:~~

~~1. The technology assisted individual who is younger than 21 years of age shall be determined to need a medical device when the individual meets one or more of the following categories:~~

~~a. Individuals depending at least part of each day on mechanical ventilators.~~

~~b. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or ongoing peritoneal dialysis.~~

~~c. Individuals having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding.~~

~~2. The technology assisted individual who is 21 years of age or older shall be determined to need a medical device when the individual meets one or more of the following categories:~~

~~a. Individuals depending at least part of each day on mechanical ventilators.~~

~~b. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or ongoing peritoneal dialysis.~~

~~3. The individual's attending physician must certify the individual's need for this level of care which must include the need for private duty nursing.~~

~~4. In addition to the medical needs identified in subdivision 1 or 2 of this subsection, the technology assisted individual shall be determined to need~~

~~substantial and ongoing skilled nursing care. This determination shall be made using an objective tool approved by DMAS. The recipient shall be required to meet a minimum standard on the Objective Scoring Criteria to be eligible to be admitted to technology assisted waiver services.~~

~~5. In addition to the medical needs identified in subdivision 1 or 2 of this subsection, Medicaid eligible individuals younger than 21 shall be admitted to this service only if the anticipated cost to Medicaid of home care will be less than or equal to the cost to Medicaid of the individual in a hospital or nursing facility.~~

~~6. In addition to the medical needs identified in subdivision 1 or 2 of this subsection, an individual older than 21 shall be admitted to this waiver service only if the anticipated cost to Medicaid of his home care will be less than or equal to the current average cost of care in a specialized nursing facility.~~

~~7. Adult Medicaid eligible individuals who entered this waiver service prior to their 21st birthday shall be required to conform to the same medical needs and individual cost effectiveness standards as specified for all other adults.~~

~~8. If a person is over age 21 and already a waiver recipient and requires admission to a nursing facility or rehabilitation hospital for more than 30 days, the recipient will be discharged from the waiver. To be readmitted to the waiver services, the recipient must be assessed to determine that the recipient currently meets the specialized nursing facility and waiver criteria. If these criteria are met, the recipient shall be readmitted to waiver services.~~

~~9. The individual shall have a primary caregiver who accepts responsibility for the individual's health and welfare. The primary caregiver shall be responsible for a minimum of eight hours of the individual's care in a 24-hour period.~~

~~10. Individuals over the age of 21 years may live in congregate living arrangements and shall have primary caregivers. Two such individuals may share the time and services of one caregiver who shall provide a minimum of eight hours of care in a 24-hour time period.~~

~~11. These services shall not be available to individuals while an inpatient in general acute care hospitals, skilled nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded, board and care facilities, or adult care residences.~~

~~12. Any individual, regardless of age, who requires admission to any type of medical care facility for fewer than 30 days shall again be eligible for waiver services upon discharge from the facility so long as all other requirements continue to be met.~~

~~C. Patient eligibility requirements.~~

~~1. Individuals receiving services under this waiver must be eligible under one of the following eligibility groups: ADC and AFDC related recipients, SSI and SSI related recipients, aged, blind or disabled recipients eligible under 42 CFR 435.121, and the special home and community based waiver group at 42 CFR 435.217 which includes individuals who are eligible under the State Plan if they were institutionalized. The income level used for the special home and community based waiver group at 42 CFR 435.217 is 300% of the current Supplemental Security Income payment standard for one person. Medically needy individuals are eligible if they meet the medically needy financial requirements for income and resources.~~

~~2. Under this waivered service, the coverage groups authorized under § 1902(a)(10)(C)(i)(III) of the Social Security Act (42 USC § 1396a(a)(10)) will be considered as if they were institutionalized for the purpose of applying institutional deeming~~

~~rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and be Medicaid eligible in an institution. The deeming rules are applied to waiver eligible individuals as if the individuals were residing in an institution or would require that level of care.~~

~~3. Virginia shall reduce its payment for home and community-based services provided for an individual by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents and medical needs have been made according to the requirements in 42 CFR 435.726. Such specified reductions shall be made as specified in 42 CFR 435.726 in the specified order from the individual's income.~~

~~4. Individuals who are eligible for third-party payment for the alternative institutional services shall not be eligible for these waivered services. If an individual or an individual's legally responsible party voluntarily cancels any insurance plan which would have provided coverage for institutional services in order to become eligible for waiver services within one year prior to the date waiver services are requested, eligibility for the waiver shall be denied.~~

12VAC30-120-90

12VAC30-120-90. ~~Covered services and provider requirements.~~(Repealed.)

~~A. Private duty nursing service shall be covered for individuals enrolled in the technology assisted waiver services. This service shall be provided through either a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract for private duty nursing or a day care center licensed by the Virginia Department of Social Services which employs registered nurses and is enrolled by DMAS to provide congregate private duty nursing. At a minimum, the private duty nurse shall either be a licensed practical nurse or a registered nurse with a current and valid license issued by the Virginia State Board of Nursing.~~

~~1. For individuals under 21 whether living separately or congregately, during the first 30 days after the individual's admission to the waiver service, private duty nursing is covered for 24 hours per day if needed and appropriate to assist the family in adjustment to the care associated with technology assistance. After 30 days, private duty nursing shall be reimbursed for a maximum of 16 hours per 24-hour period per household. The department may grant individual exceptions, not to exceed 30 total days per annum, to these maximum limits based on documented emergency needs of the individual and the case, which continue to meet requirements for cost effectiveness of community services. Such consideration of documented emergency needs shall not include applicable additional emergency costs.~~

~~2. For individuals over the age of 21 years whether living separately or congregately, private duty nursing shall be reimbursed for a maximum of 16 hours within a 24-hour period per household provided that the cost-effectiveness standard is not exceeded for the individual's care.~~

~~3. In no instance, shall DMAS approve an ongoing plan of care or ongoing multiple plans of care per household which result in approval of more than 16 hours of private duty nursing in a 24-hour period per household.~~

~~4. Individuals who no longer meet the patient qualifications for either children or adults cited in 12VAC30-120-80 may be eligible for private duty nursing for the number of hours per 24-hour period previously approved in the plan of care not to exceed two weeks from the date the attending physician certifies the cessation of daily technology assistance.~~

~~5. The hours of private duty nursing approved for coverage shall be limited by either medical necessity or cost effectiveness or both.~~

~~6. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two waiver recipients. When three or more waiver recipients share a home, ratios will be determined by the combined needs of the residents.~~

~~B. Provided that the cost-effectiveness standard shall not be exceeded, respite care service shall be covered for a maximum of 360 hours within a calendar year per household for individuals who are qualified for technology assisted waiver services and who have a primary caregiver, other than the provider, who requires relief from the burden of caregiving. This service shall be provided by skilled nursing staff (registered nurse or licensed practical nurse licensed to practice in the Commonwealth) under the direct supervision of a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract to provide private duty nursing.~~

~~C. Provided that the cost-effectiveness standard shall not be exceeded, durable medical equipment and supplies shall be provided for individuals qualified for technology services. All durable medical equipment and supplies, including nutritional supplements, which are covered under the State Plan and those medical equipment and supplies, including such items which may be defined as assistive technology and environmental modifications which are not covered under the State Plan but are medically necessary and cost effective for the individual's maintenance in the community, shall be covered. This service shall be provided by persons qualified to render it. Durable medical equipment and supplies shall be necessary to maintain the individual in the home environment.~~

~~1. Medical equipment and supplies shall be prescribed by the attending physician and included in the plan of care, and must be generally recognized as serving a diagnostic or therapeutic purpose and being medically necessary for the home care of the individual.~~

~~2. Vendors of durable medical equipment and supplies related to the technology upon which the individual is dependent shall have a contract with DMAS to provide services.~~

~~3. In addition to providing the ventilator or other respiratory-deviced support and associated equipment and supplies, the vendor providing the ventilator shall ensure the following:~~

~~a. 24 hour on-call for emergency services;~~

~~b. Technicians to make regularly scheduled maintenance visits at least every 30 days and more often if called;~~

~~c. Replacement or repair of equipment and supplies as required; and~~

~~d. Respiratory therapist registered or certified with the National Board for Respiratory Care (NBRC) on call 24 hours per day and stationed within two hours of the individual's home to facilitate immediate response. The respiratory therapist shall be available for routine respiratory therapy as well as emergency care. In the event that the Department of Health Professions implements through state law a regulation requiring registration, certification or licensure for respiratory therapists to practice in the Commonwealth, DMAS shall require all respiratory therapists providing services to this technology assisted population to be duly registered, licensed or certified.~~

~~D. Provided that the cost-effectiveness standard shall not be exceeded, personal assistance services shall be covered for individuals over the age of 21 who require some assistance with activities of daily living and instrumental activities of daily~~

~~living but do not require and are able to do without skilled interventions during portions of their day or are able to self perform a portion of their ADLs or IADLs or direct their skilled care needs during the period when personal assistance would be provided. Personal assistance services shall be rendered by a provider who has a DMAS provider agreement to provide personal care, home health care, and private duty nursing. At a minimum, the staff providing personal assistance must have been certified through coursework as either personal care aides, home health aides, homemakers, personal care attendants, or registered or certified respiratory therapists.~~

~~E. Assistive technology services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-762 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

~~F. Environmental modifications services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-758 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

~~G. Transition services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

12VAC30-120-100
12VAC30-120-100. ~~Provider reimbursement.~~ (Repealed.)

~~A. All private duty nursing services shall be reimbursed at an hourly negotiated fee.~~

~~B. Respite care shall be reimbursed at an hourly negotiated fee.~~

~~C. Prior approval for durable medical equipment and supplies shall be requested from DMAS by the durable medical equipment provider. Prior approval by DMAS shall be required for all durable medical equipment and other medically related supplies furnished under this program before the individual's admission to waiver services and before reimbursement. If additional equipment and supplies are needed following the individual's admission to waiver services, the durable medical equipment provider must obtain DMAS' prior approval. This prior authorization requirement shall apply to all durable medical equipment and supplies that are covered under the State Plan or the waiver.~~

~~D. Personal assistance shall be reimbursed at an hourly negotiated fee.~~

~~E. Effective July 1, 2008, agency-directed individual supported employment rates shall be paid at the same provider-specific rates paid by the Department of Rehabilitative Services.~~

12VAC30-120-110
12VAC30-120-110. ~~Assessment and plan of care requirements.~~(Repealed.)

~~A. The attending physician and a health care coordinator must participate in the approval of the initial assessment and the number of hours of nursing service required.~~

~~1. The physician shall be currently certified by the Board of Medicine and have a currently valid license to practice medicine in the Commonwealth. The physician shall have experience in the needs and care of technology assisted persons and the needs of children if the individual being admitted to waiver services is a child.~~

~~2. The health care coordinator must be currently and validly licensed to practice nursing in the Commonwealth. The nurse shall have experience in the needs and~~

~~care of technology assisted persons and the needs of children if the individual being admitted to waiver services is a child.~~

~~3. Other specialists who are currently and validly licensed, registered or certified to practice their specialities within the Commonwealth may participate in the assessment and care planning process. These other specialists shall have experience in the needs and care of technology assisted persons and the needs of children if the person being admitted to waiver services is a child.~~

~~4. The health care coordinator shall be responsible for ensuring that the assessment, care planning, monitoring, and review activities required by DMAS are accomplished and documented consistent with DMAS' requirements. For individuals over the age of 21, the health care coordinator must determine that the minimum established nursing facility criteria are met.~~

~~B. Referral for waiver services and assessment.~~

~~1. For individuals under age 21, a service referral may originate from either the clinical staff in the hospital where the individual is located or from a health care professional in the community where the individual is receiving non-Medicaid funded home and community-based services. For individuals over age 21, the referral may originate from the discharge planning staff in the nursing facility where the individual resides or from persons in the community who are aware of the needs of the individual.~~

~~2. The health care coordinator shall first determine that Medicaid would be the source of payment for the individual's institutional care if waiver services are not available. An individual for whom third-party payment is available for the alternative institutional care is not eligible for the waiver service nor is an individual whose insurance has been voluntarily dropped in anticipation of waiver application and an assessment for waiver services is not to be completed.~~

~~3. Upon receiving consent from the legally competent recipient or the recipient's legal guardian or the parent of a minor child to explore the possibility of home care, the health care coordinator shall arrange for the assessment process for waiver services. The attending physician and a health care coordinator must participate in the approval of the initial assessment and the number of hours of nursing service required.~~

~~4. At the time of assessment, certification from the attending physician that the individual would otherwise require continued acute care or specialized nursing facility care shall be necessary to continue the assessment process.~~

~~5. Upon the completion of the assessment process the health care coordinator shall make a determination of the need for substantial and ongoing skilled nursing care. This determination will be made using an objective tool approved by DMAS. For admission to or continuation in the technology assisted waiver program, the recipient will be required to meet a score of 50 or more on the Objective Scoring Criteria form.~~

~~C. Development of the plan of care.~~

~~1. Upon completion of the required assessments and a determination that the individual needs substantial and ongoing skilled nursing care, the hours of nursing service required is developed and approved by the health care coordinator.~~

~~2. At minimum, the plan of care shall include:~~

~~a. A statement of the appropriateness of the home in which the individual is to be placed.~~

~~b. Identification of the type, frequency, and amount of nursing care and personal assistance needed. This shall include the name of the provider agency, whether the nurse is an RN or an LPN, and verification that the nurse is licensed to practice in the Commonwealth and the professional qualifications of the personnel required to provide personal assistance. This shall also contain documentation that the health care coordinator has verified that the provider agency is an enrolled provider with DMAS to provide the appropriate waiver services for the individual.~~

~~c. Identification of all other services that are needed for the individual to be maintained in the home. The statement shall include, as appropriate, speech therapy, occupational therapy, physical therapy, transportation, physician services, the frequency and amount of service needed, the provider of the service, and the payment source.~~

~~d. A complete list of equipment and supply needs, and identification of the provider and source of payment.~~

~~e. Identification of the type, frequency, and amount of care that the family or other informal care givers shall provide.~~

~~f. Other referrals for assessment for services (as needed and appropriate) to include but not be limited to the school system; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); child development clinic services; and Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) services.~~

~~g. Identification of the primary care physician in the community who has agreed to manage the medical care of the individual in the community.~~

~~h. The appropriateness of the medical care, including a statement from the individual's primary care physician, to be signed by the legally responsible adult, attesting that the medical care the individual is to receive in the home is agreed to by the legally responsible adult and all others involved in the assessment process referred to in this section.~~

~~D. Cost effectiveness computations.~~

~~1. Cost effectiveness computations shall be completed by the health care coordinator upon completion of the plan of care for any individual entering the waiver.~~

~~2. For individuals over 21, the health care coordinator shall be required to document the anticipated cost to DMAS for the individual's waiver services for a 12-month period. The health care coordinator shall then compare DMAS' costs for the waiver to the average costs to DMAS for specialized nursing facility care for the individual.~~

~~3. For individuals under 21, the health care coordinator shall be required to document the anticipated cost to DMAS for the individual's waiver services for a 12-month period. The health care coordinator shall then compare DMAS' costs for the waiver to the average costs to DMAS for continued hospitalization of the individual.~~

~~E. Patient selection of waiver services.~~

~~1. The health care coordinator shall give the legally competent recipient or the recipient's legal guardian or the parent of a minor child the choice of waiver services or institutionalization.~~

~~2. If waiver services are chosen, the applicant or his legally responsible adult will also be given the opportunity to choose the providers of service, if more than one provider is available to render the services. If more than one waiver recipient will~~

~~reside in the home, one waiver provider shall be chosen to provide all private duty nursing services for all waiver recipients in the home. Only one nurse will be authorized to care for each two waiver recipients in a home. In the instance when more than two waiver participants share a home, nursing ratios will be determined by the health care coordinator based on the needs of all the recipients living together.~~

~~F. DMAS shall review and approve the assessment, plan of care, cost effectiveness, and choice of providers prior to the individual's admission to community waiver services, and prior to Medicaid payment for any services related to the waiver plan of care.~~

12VAC30-120-115
12VAC30-120-115. ~~Reevaluation requirements and utilization review.~~ (Repealed.)

~~A. The need for reevaluations shall be determined by the health care coordinator. Reevaluations shall be conducted by the health care coordinator as required by the individual's needs and situation and at any time when a change in the individual's condition indicates the need for reevaluation.~~

~~B. DMAS is responsible for performing utilization review at least every six months and for the maintenance of supporting documentation. DMAS shall maintain a copy of the plan of care, the initial evaluation, and each reevaluation for the minimum period required by federal and state law.~~

~~C. The health care coordinator shall review the plan of care for appropriateness of the level, amount, type, and quality of services provided as well as for monitoring the cost effectiveness of the individual's care in the community.~~

~~D. Medical necessity of waiver services shall be reviewed by the health care coordinator and DMAS.~~

~~E. If the health care coordinator or DMAS determines, during utilization review or at any other time, that the waiver individual no longer meets cost-effectiveness standards or medical needs criteria, then the health care coordinator or DMAS, as appropriate, shall deny payment for such waiver individual with the exception of a child or adult who no longer meets the patient qualifications of 12VAC30-120-80 who may be eligible for private duty nursing for the number of hours previously approved in the plan of care per 24-hour period not to exceed two weeks from the date the attending physician certifies the cessation of daily technology assistance.~~

12VAC30-120-120
12VAC30-120-120. ~~Appeal of denied coverage.~~ (Repealed.)

~~A. DMAS shall provide the opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to individuals who are not given the choice of home and community-based services as an alternative to receiving hospital or nursing facility services or who are denied the amount or type of service of their choice or the provider of their choice. Persons who are discharged from waiver services shall also have the right to file an appeal.~~

~~B. The individual shall be advised in writing of the denial and of his right to appeal consistent with DMAS client appeals (12VAC30-110-10 through 12VAC30-110-600).~~

12VAC30-120-1700
Part IX
Home and Community-Based Services for Technology Assisted Individuals

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-1700. Definitions.

The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise:

[~~"Abuse" means the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse, or exploitation of a waiver individual. Types of abuse include: (i) physical abuse (a physical act by a person that may cause physical injury to an individual); (ii) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear or humiliate, intimidate, degrade, or demean an individual); (iii) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation, sexual harassment, or inappropriate or unwanted touching of an individual); and (iv) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate an individual).~~]

"Activities of daily living" or "ADLs" means personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Adult" means an individual who is either 21 years of age or older.

"Adult foster care" means room and board, supervision, and a locally optional program that may be provided by a single provider for up to three adults who has or have a physical or mental condition. The provider must be approved by the local department of social services for the locality in which the provider renders services.

"Adult Protective Services" or "APS" means a program overseen by the Virginia Department of Social Services that investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over 18 years of age and provides services when such persons are found to be in need of protective services.

"Agency provider" means a public or private organization or entity that holds a Medicaid provider agreement and furnishes services to individuals using its own employees or subcontractors.

"Alternate back up facility" means the alternate facility placement that the technology assisted individuals must use when home and community-based waiver services are interrupted. Such facilities may be, for the purpose of this waiver, an intermediate care facility for the [~~mentally retarded (ICF/MR)~~ intellectually disabled (ICF/ID)] , a long-stay hospital, a specialized care nursing facility, or an acute care hospital when all technology assisted waiver criteria are met.

"Americans with Disabilities Act" or "ADA" means the United States Code pursuant to 42 USC § 12101 et seq., as amended.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

"Applicant" means an individual (or representative on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to the technology assisted waiver.

"Assess" means to evaluate an applicant's or an individual's condition, including functional status, current medical status, psychosocial history, and environment. Information is collected from the applicant or individual, applicant's or individual's

representative, family, and medical professionals, as well as the assessor's observation of the applicant or individual

"Assessment" means one or more processes that are used to obtain information about an applicant, including his condition, personal goals and preferences, functional limitations, health status, financial status and other factors that are relevant to the determination of eligibility for services and is required for the authorization of and provision of services, and forms the basis for the development of the plan of care.

"Assistive technology" or "AT" means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance, that (i) enable individuals to increase their abilities to perform [~~ADLs~~ ADLs/IADLs] and to perceive, control, or communicate with the environment in which they live or (ii) are necessary for the proper functioning of the specialized equipment; cost effective; and appropriate for the individual's assessed medical needs and physical deficits.

"Backup caregiver" means the secondary person who will assume the role of providing direct care to and support of the waiver individual in instances of emergencies and in the absence of the primary caregiver who is unable to care for the individual. Such secondary persons shall perform the duties needed by the waiver individual without compensation and shall be trained in the skilled needs and technologies required by the waiver individual. Such secondary persons must be identified in the waiver individual's records.

"Barrier crime" means those crimes as defined in § 32.1-162.9:1 of the Code of Virginia that would prohibit [either]the [employment of or the] continuation of employment if a person is found, through a Virginia State Police criminal history record check, to have been convicted of such a crime.

"CMS-485 Home Health Certification form" means the federal Home Health Service Plan form.

"Center for Medicare and Medicaid Services" or "CMS" means the unit of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Child Protective Services" or "CPS" means a program overseen by the Department of Social Services which investigates reports of abuse, neglect, and exploitation of children under 18 years of age and provides services when persons are found to be in need of protective services.

"Code of Federal Regulations" or "CFR" contains the regulations that have been officially adopted by federal agencies and have the force and effect of federal law.

"Congregate living arrangement" means a living arrangement in which three or fewer waiver individuals live in the same household and share receipt of health care services from the same provider or providers.

"Congregate skilled private duty nursing" means skilled in-home nursing provided to three or fewer waiver individuals in the individuals' primary residence or a group setting.

"Congregate private duty respite" means skilled respite care provided to three or fewer waiver individuals. This service shall be limited to [~~240~~ 360] hours per calendar year per household.

"Cost-effective" means the anticipated annual cost to Medicaid for technology assisted waiver services shall be less than or equal to the anticipated annual

institutional costs to Medicaid for individuals receiving care in hospitals or specialized care nursing facilities.

"Day" means, for the purpose of reimbursement under this waiver, a 24-hour period beginning at 12 a.m. and ending at 11:59 p.m.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services.

"Direct marketing" means one of the following: (i) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregiver, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual and the individual's family/caregiver, as appropriate, use of the providers' services.

"Direct medical benefit" means services or supplies that are proper and needed for the diagnosis or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of the condition; and meet the standards of good professional medical practice.

"Direct supervision" means that the supervising registered nurse (RN) is immediately accessible by phone to the RN, licensed practical nurse or personal care aide who is delivering waiver covered services to individuals.

"Durable medical equipment (DME) and supplies" means those items prescribed by the attending physician, generally recognized by the medical community as serving a diagnostic or therapeutic purpose to assist the waiver individual in the home environment, and as being a medically necessary element of the service plan without regard to whether those items are covered by the State Plan for Medical Assistance.

"Eligibility determination" is the process to determine whether an individual meets the eligibility requirements specified by DMAS to receive Medicaid benefits and continues to be eligible as determined annually.

"Enrolled provider" means those professional entities or facilities who are registered, certified, or licensed, as appropriate, and who are also enrolled by DMAS to render services to eligible waiver individuals and receive reimbursement for such services.

"Enrollment" means the process where an individual has been determined to meet the eligibility requirements for a Medicaid program or service and the approving entity has verified the availability of services for the individual requesting waiver enrollment and services.

"Environmental modifications" or "EM" means physical adaptations to an individual's primary residence or primary vehicle that are necessary to ensure the individual's health, safety, or welfare or that enable the individual to function with greater independence and without which the individual would require institutionalization.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under 21 years of age according to federal

guidelines that prescribe preventive and treatment services for Medicaid-eligible children as set out in 12VAC30-50-130.

"Evaluation tool" means the tool that is used to determine the medical appropriateness for technology assisted waiver enrollment or services. Individuals younger than 21 years of age shall be assessed using the Technology Assisted Waiver Pediatric Referral Form (DMAS-109) and individuals 21 years of age or older shall be assessed using the Technology Assisted Waiver Adult Referral form (DMAS-108).

"Freedom of choice" means the right afforded an individual who is determined to require a level of care specified in a waiver to choose (i) either institutional or home and community-based services provided there are available funded slots, (ii) providers of services, and (iii) waiver services as may be limited by medical necessity.

"Functional status" means an individual's degree of dependence in performing [~~ADLs~~ ADLs/IADLs].

"Health, safety, and welfare standard" means that an individual's right to receive a waiver service is dependent on a DMAS determination that the waiver individual needs the medically necessary service based on appropriate assessment criteria and an approved written plan of care and that medically necessary services can be safely provided in the community.

"Home and community-based waiver services" or "waiver services" means the range of home and community services approved by the CMS pursuant to § 1915 (c) of the Social Security Act to be offered to individuals as an alternative to institutionalization.

"Individual" means the person who has applied for and been approved to receive technology assisted waiver services.

"Individual's representative" means a spouse, guardian, adult child, parent (natural, adoptive, step, or foster) of a minor child, or other person chosen by the member to represent him in matters relating to his care or to function as the member's primary caregiver as defined herein.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, and laundry. An individual's degree of independence in performing these activities is a part of determining the appropriate level of care and service needs.

"Legally responsible person" means one who has a legal obligation under the provisions of state law to care for and make decisions for an individual. Legally responsible persons shall include the parents (natural, adoptive, or legal guardian) of minor children, and legally assigned caregiver relatives of minor children.

"Level of care" or "LOC" means the specification of the minimum amount of assistance an individual must require in order to receive services in an institutional setting under the State Plan for Medical Assistance Services or to receive waiver services.

"License" means proof of official or legal permission issued by the government for an entity or person to perform an activity or service. In the absence of a license that may be required by either statute or regulation, the entity or person shall be prohibited from performing the activity or service for reimbursement by DMAS.

"Licensed practical nurse" or "LPN" means a person who is licensed or holds a multi-state licensure privilege, pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, to practice practical nursing as defined.

"Long-term care" or "LTC" means a variety of services that help individuals with health or personal care needs and ADLs over a period of time. Long-term care can be provided in the home, in the community, or in various types of facilities, including nursing facilities, long-stay hospitals, and [~~ICFs/MR~~ ICF/IDs].

"Medicaid" means the joint federal and state program to assist the states in furnishing medical assistance to eligible needy persons pursuant to Title XIX of the Social Security Act (42 USC § 1396 et seq.).

"Medicaid Long Term Care Communication Form" or "DMAS-225" means the form used to exchange eligibility information of a Medicaid-eligible individual or other information that may affect the individual's eligibility status.

"Medically necessary" means those services or specialized medical equipment or supplies that are covered for reimbursement under either the State Plan for Medical Assistance or in a waiver program that are reasonable, proper, and necessary for the treatment of an illness, injury, or deficit; are provided for direct care of the condition or to maintain or improve the functioning of a malformed body part; and that meet the standards of good professional medical practice as determined by DMAS.

"Minor child" means an individual who is younger than 21 years of age.

"Money Follows the Person" or "MFP" means the [demonstration] program [~~of transition services and coordination~~] as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

"Monitoring" means the ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the waiver individual's plan of care and effectively meet his needs, thereby assuring his health, safety, and welfare. Monitoring activities may include, but shall not be limited to, telephone contact; observation; interviewing the individual or the trained individual representative, as appropriate, in person or by telephone; or interviewing service providers.

"Participating provider" or "provider" means an entity that meets the standards and requirements set forth by the appropriate licensing or certification agencies and who has a current, signed provider participation agreement with DMAS.

"Payor of last resort" means all other payment sources must be exhausted before enrollment in the technology assisted waiver and Medicaid reimbursement may occur.

"Personal care aide" or "PCA" means an appropriately licensed or certified person who provides personal care services.

"Personal care provider" means an enrolled provider that renders services that prevent or reduce institutional care by providing eligible waiver individuals with PCAs who provide personal care services.

"Personal care (PC) services" means a range of support services that includes assistance with [~~ADLs~~ADLs/IADLs], access to the community, and self-administration of medication or other medical needs, and the monitoring of health status and physical condition provided through the agency-directed model. Personal care services shall be provided by PCAs within the scope of their licenses or certifications, as appropriate.

"Person-centered planning" means a process, directed by the individual or his representative, as appropriate, that is intended to identify the strengths, capacities, preferences, needs, and desired outcomes for the individual.

"Plan of care" or "POC" means the written plan of waiver services and supplies ordered and certified by the attending physician as being medically needed by the individual to ensure optimal health and safety for an extended period of time while the individual is living in the community. This POC shall be developed collaboratively by the individual or individual representative, as appropriate.

"Preadmission screening" or "PAS" means the process to (i) evaluate the functional, nursing, and social support needs of applicants referred for preadmission screening; (ii) assist applicants in determining what specific services the applicants need; (iii) evaluate whether a service or a combination of existing community services are available to meet the applicants' needs; and (iv) refer applicants to the appropriate provider for Medicaid-funded facility or home and community-based care for those who meet specialized care nursing facility level of care.

"Preadmission screening team" or "PAS team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

[~~"Prior authorization" or "PA" (also "service authorization") means the process of approving either by DMAS or its prior authorization (or service authorization) contractor for the purposes of DMAS reimbursement for the service for the individual before it is rendered.~~]

[~~"Prior authorization contractor" means DMAS or the entity that has been contracted by DMAS to perform prior authorization for medically necessary Medicaid reimbursed home and community-based services.~~]

"Provider agreement" means the contract between DMAS and a participating provider under which the provider agrees to furnish services to Medicaid-eligible individuals in compliance with state and federal statutes and regulations and Medicaid contract requirements.

"Reevaluation" means the periodic but at least annual review of an individual's condition and service needs to determine whether the individual continues to meet the LOC specified for persons approved for waiver participation.

"Registered nurse" or "RN" means a person who is licensed or holds a multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice professional nursing as defined.

["Service authorization" or "Serv Auth" means the DMAS approval of a requested medical service for reimbursement prior to the provision of the service. Service authorizations shall be performed by DMAS or its service authorization contractor.]

["Service authorization contractor" means DMAS or the entity that has been contracted by DMAS to perform service authorization for medically necessary Medicaid reimbursed home and community-based services.]

"Single state agency" means the agency within state government that has been designated pursuant to § 1902(a)(5) of the Act as responsible for the administration of the State Plan for Medical Assistance. In Virginia, the single state agency is DMAS.

"Skilled private duty nursing respite care provider" means a DMAS participating provider that renders services in the individual's designated primary care residence to offer periodic or routine relief for unpaid primary caregivers.

"Skilled private duty nursing respite care services" means temporary skilled nursing services provided in the waiver individual's primary residence that are designed to relieve the unpaid primary caregiver on an episodic or routine basis for short periods or for specified longer periods of time.

"Skilled private duty nursing services" or "skilled PDN" means skilled in-home nursing services listed in the POC that are (i) not otherwise covered under the State Plan for Medical Assistance Services home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, respectively); and (iv) provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver members who have serious medical conditions or complex health care needs. Skilled nursing services are to be used as hands-on member care, training, consultation, as appropriate, and oversight of direct care staff, as appropriate.

"State Plan for Medical Assistance" or "State Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Technology assisted waiver" or "tech waiver" means the CMS-approved waiver that provides medically necessary covered services to individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care to avert death or further disability and whose illness or disability would, in the absence of services approved under this waiver, require their admission for a prolonged stay in a hospital or specialized care nursing facility.

"Termination" means disenrollment from a waiver by DMAS or a DMAS-designated agent.

"Transition services" means set-up expenses for individuals as defined at 12VAC30-120-2010.

"Virginia Department of Health" or "VDH" means the state Health Department.

"VDSS" means the Virginia Department of Social Services.

"Ventilator dependence" means that the waiver individual is dependent on such machines in order to sustain life or compensate for the loss of body function.

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that assesses an individual's physical health, mental health, psychosocial, and functional abilities to determine if the individual meets the nursing facility LOC.

12VAC30-120-1705
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-1705. Waiver description and legal authority.

A. Home and community-based waiver services shall be available through a § 1915(c) waiver of the Social Security Act. Under this waiver, DMAS has waived § 1902(a) (10) (B) and (C) of the Social Security Act related to comparability of services.

B. Technology assisted waiver services shall be covered only for Medicaid-eligible individuals who have been determined eligible for waiver services and who also require the level of care provided in either long-stay hospitals or specialized care nursing facilities as long as age appropriate criteria are met. These services shall

be the critical service necessary to delay or avoid the individual's placement in an appropriate facility. These waiver services shall not be covered for Medicaid-eligible individuals who reside in, but not necessarily limited to, the following types of facilities: assisted living facilities, nursing facilities, rehabilitation hospitals, long-stay hospitals, skilled or intermediate care nursing facilities, Intermediate Care Facilities for the [~~Mentally Retarded~~ Intellectually Disabled] , group homes licensed by DBHDS, general acute care hospitals or adult foster care homes.

C. An individual [~~must~~shall] demonstrate the medical necessity for skilled private duty nursing services in order to be approved for this waiver.

D. The cost effectiveness standard that shall be applied for individuals in this waiver shall be in the aggregate.

E. [~~Tech waiver services shall not be offered or provided to an individual who resides outside of the continental~~ United States or travels out of the ~~Commonwealth. However, brief absences~~ from the Commonwealth for up to 14 ~~days per calendar year may be made for vacationsbut such absences shall be authorized by DMAS, and limited to the same number of skilled PDN hours approved for the individual's home based skilled PDN.~~ Payments for Tech Waiver services shall not be provided to any financial institution or entity located outside of the United States pursuant to the *Social Security Act* § 1902(a)(80). Payments for Tech Waiver services furnished in another state shall (1) be provided for an individual who meets the requirements of 42 CFR § 431.52, and (2) be limited to the same number of skilled PDN hours approved for the individual's home-based skilled PDN.] .

F. An individual shall not simultaneously be in a managed care program and enrolled in this waiver. An individual shall not be simultaneously enrolled in more than one waiver program.

G. For individuals admitted to this waiver, when their waiver services must be interrupted due to their primary caregiver's emergency unavailability, then hospitalization or placement in a specialized nursing facility, should a specialized care nursing facility bed be available, shall occur.

H. DMAS shall be responsible for assuring appropriate placement of the individual in home and community based waiver services and shall have the authority to terminate such services.

I. No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed.

12VAC30-120-1710
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-1710. Individual eligibility requirements; preadmission screening.

A. Individual eligibility requirements.

1. The Commonwealth covers these optional categorically needy groups: ADC and AFDC-related individuals, SSI and SSA-related individual, aged, blind, or disabled Medicaid-eligible individuals under 42 CFR 435.121, and the home and community-based waiver group at 42 CFR 435.217 that includes individuals who are eligible under the State Plan if they were institutionalized.

a. The income level used for the home and community-based waiver group at 42 CFR 435.217 shall be 300% of the current Supplemental Security Income payment standard for one person.

b. Medically needy Medicaid-eligible individuals shall be eligible if they meet the medically needy financial requirements for income and resources.

2. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act shall be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All individuals in the waiver must meet the financial and non-financial Medicaid eligibility criteria and meet the institutional LOC criteria. The deeming rules shall be applied to waiver eligible individuals as if they were residing in an institution or would require that level of care.

3. An applicant for technology assisted waiver shall meet specialized care nursing facility criteria, including both medical and functional needs, and also be dependent on waiver services to avoid or delay facility placement and meet all criteria for the age appropriate assessments in order to be eligible for the tech waiver. Applicants shall not be enrolled in the tech waiver unless skilled PDN hours are ordered by the physician. The number of skilled PDN hours shall be based on the total technology and nursing score on the Technology Assisted Waiver Pediatric Referral (when individuals are less than 21 years of age). The number of skilled PDN hours for adults shall be based on the Technology Assisted Waiver Adult Referral (DMAS-108).

4. Applicants who are eligible for third-party payment for skilled private duty nursing services shall not be eligible for these waiver services. If an individual or an individual's legally responsible party voluntarily drops any insurance plan that would have provided coverage of skilled private duty nursing services in order to become eligible for these waiver services within one year prior to the date waiver services are requested, eligibility for the waiver shall be denied. From the date that such insurance plan is discontinued, such applicants shall be barred for one year from reapplying for waiver services. After the passage of the one-year time period, the applicant may reapply to DMAS for admission to the tech waiver.

5. In addition to the medical needs identified in this section, the Medicaid-eligible individual shall be determined to need substantial and ongoing skilled nursing care. The Medicaid-eligible individual shall be required to meet a minimum standard on the age appropriate referral forms to be eligible for enrollment in the tech waiver.

6. Medicaid-eligible individuals who entered the waiver prior to their 21st birthday shall, on the date of their 21st birthday, conform to the adult medical criteria and cost-effectiveness standards.

7. Every individual who applies for Medicaid-funded waiver services must have his Medicaid eligibility evaluated or re-evaluated, if already Medicaid eligible, by the local DSS in the city or county in which he resides. This determination shall be completed at the same time the Pre-admission Screening (PAS) team completes its evaluation (via the use of the Uniform Assessment Instrument (UAI)) of whether the applicant meets waiver criteria. DMAS payment of waiver services shall be contingent upon the DSS' determination that the individual is eligible for Medicaid services for the dates that waiver services are to be provided and that DMAS or the designated [~~prior~~ service] authorization contractor has authorized waiver enrollment and has prior authorized the services that will be required by the individual.

8. In order for an enrolled waiver individual to retain his enrolled status, tech waiver services must be used by the individual at least once every 30 days. Individuals who do not utilize tech waiver services at least [once] every 30 days shall be terminated from the waiver.

9. The waiver individual shall have a trained primary caregiver, as defined in 12VAC30-120-1700, who accepts responsibility for the individual's health, safety, and welfare. This primary caregiver shall be responsible for a minimum of eight hours of the individual's care in a 24-hour period as well as [~~any~~ all] hours not provided by an RN or an LPN. The name of the trained primary caregiver shall be documented in the provider agency records. This trained primary caregiver shall also have a back up system available in emergency situations.

B. Screening and community referral for authorization for tech waiver. Tech waiver services shall be considered only for individuals who are eligible for Medicaid and for admission to a specialized care nursing facility, [~~ICF/MR~~ ICF/ID], long-stay hospital, or acute care hospital when those individuals meet all the criteria for tech waiver admission. Such individuals, with the exception of those who are transferring into this tech waiver from a long-stay hospital, shall have been screened using the Uniform Assessment Instrument (UAI).

1. The screening team shall provide the individual and family or caregiver with the choice of tech waiver services or specialized care nursing facility or long-stay hospital placement, as appropriate, as well as the provider of those services from the time an individual seeks waiver information or application and referral. Such provision of choice includes the right to appeal pursuant to 12VAC30-110 when applicable.

2. The screening team shall explore alternative care settings and services to provide the care needed by the applicant being screened when Medicaid-funded home and community based care services are determined to be the critical service necessary to delay or avoid facility placement.

3. Individuals must be screened to determine necessity for nursing facility placement if the individual is currently financially Medicaid eligible or anticipates that he will be financially eligible within 180 days of the receipt of nursing facility care or if the individual is at risk of nursing facility placement.

a. Such covered waiver services shall be critical, as certified by the participant's physician at the time of assessment, to enable the individual to remain at home and in the community rather than being placed in an institution. In order to meet criteria for tech waiver enrollment, the applicant requesting consideration for waiver enrollment must meet the level of care criteria.

b. Individuals who are younger than 21 years of age shall have the Technology Assisted Waiver Pediatric Referral Form (DMAS-109) completed and must [~~need~~ require] substantial and ongoing nursing care as indicated by a minimum score of at least 50 points to qualify for waiver enrollment. This individual shall [~~need~~require] a medical device and ongoing skilled PDN care by meeting the categories described in subdivision (1), (2), or (3) below:

(1) Applicants depending on mechanical ventilators;

(2) Applicants requiring prolonged intravenous administration of nutritional substances or drugs or requiring ongoing peritoneal dialysis; or

(3) Applicants having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding.

c. Individuals who are 21 years of age or older shall have the Technology Assisted Waiver Adult Referral Form (DMAS-108) completed and must be [~~found~~ determined] to be dependent on a ventilator or must meet all eight specialized care criteria (12VAC30-60-320) for complex tracheostomy care in order to qualify for waiver enrollment.

4. When an applicant has been determined [~~by DSS~~] to meet the financial and waiver eligibility requirements and DMAS has verified the availability of the services for that individual and that the individual has no other payment sources for skilled PDN, tech waiver enrollment and entry into home and community-based care may occur.

5. Preadmission screenings are considered valid for the following time frames for all LTC services. The following time frames apply to individuals who have been screened but have not received either institutional or community based services during the periods shown below:

a. Zero to six months: screenings are valid and do not require updates;

b. Six months to 12 months: screening updates are required; however, no additional reimbursement is made by DMAS; and

c. Over 12 months: a new screening is required. Additional reimbursement shall be made by DMAS for the repeated screening.

6. When an individual was not screened prior to admission to a specialized care nursing facility, or the individual resides in the community at the time of referral initiation to DMAS, the locality in which the individual resides at the time of discharge [~~must~~shall] complete the preadmission screening prior to enrollment into the tech waiver.

7. [~~The individual's attending physician and~~] DMAS shall be the final determining [~~bodies~~ body] for enrollment in the tech waiver and the determination of the number of approved skilled PDN hours for which DMAS will pay. DMAS has the ultimate responsibility for authorization of [waiver enrollment and] Medicaid skilled PDN reimbursement for tech waiver services.

C. Waiver individuals' rights and responsibilities. DMAS shall ensure that:

1. Each waiver individual shall receive [,] and the provider and provider staff shall provide[,] the necessary care and services, to the extent of provider availability, to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the individual's comprehensive assessment and POC.

2. Waiver individuals shall have the right to receive services from the provider with reasonable accommodation of the individuals' needs and preferences except when DMAS makes a determination that the health, safety, or welfare of the individuals or other waiver individuals would be endangered.

3. Waiver individuals formulate their own advance directives based on information that providers must give to adult waiver individuals at the time of their admissions to services.

4. All waiver individuals shall have the right to:

a. Voice grievances to the provider or provider staff without discrimination or reprisal. Such grievances include those with respect to treatment that has been furnished or has not been furnished;

b. Prompt efforts by the provider or staff, as appropriate, to resolve any grievances the waiver individual may have;

c. Be free from verbal, sexual, physical, and mental abuse, neglect, exploitation, and misappropriation of property;

d. Be free from any physical or chemical restraints of any form that may be used as a means of coercion, discipline, convenience, or retaliation and that are not required to treat the individual's medical symptoms; and

e. Their personal privacy and confidentiality of their personal and clinical records.

5. Waiver individuals shall be provided by their healthcare providers, at the time of their admission to this waiver, with written information regarding their rights to participate in medical care decisions, including the right to accept or refuse medical treatment and the right to formulate advance directives.

6. The legally competent waiver individual, the waiver individual's legal guardian, or the parent (natural, adoptive or foster) of the minor child shall have the right to:

a. Choose whether the individual wishes to receive home and community-based care waiver services instead of institutionalization in accordance with the assessed needs of the individual. The PAS team shall inform the individual of all available waiver service providers in the community in which the waiver individual resides. The tech waiver individual shall have the option of selecting the provider and services of his choice. This choice must be documented in the individual's medical record;

b. Choose his own primary care physician in the community in which he lives;

c. Be fully informed in advance about the waiver POC and treatment needs as well as any changes in that care or treatment that may affect the individual's well-being; and

d. Participate in the care planning process [~~and,~~] choice [and scheduling] of providers and services.

12VAC30-120-1720
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-1720. Covered services; limits; changes to or termination of services.

A. Coverage statement.

1. These waiver services shall be medically necessary, cost-effective as compared to the costs of institutionalization, and necessary to maintain the individual safely in the community and prevent institutionalization.

2. Services shall be provided only to those individuals whose service needs are consistent with the service description and for which providers are available who have adequate and appropriate staffing to meet the needs of the individuals to be served.

3. All services covered through this waiver shall be rendered according to the individuals' POCs that have been certified by physicians as medically necessary and also reviewed by DMAS to enable the waiver enrolled individuals to remain at home or in the community.

4. Providers shall be required to refund payments received to DMAS if they (i) are found during any review to have billed Medicaid contrary to policy, (ii) have failed to maintain records to support their claims for services, or (iii) have billed for medically unnecessary services.

5. DMAS shall perform [~~prior~~service] authorization for skilled PDN services, [~~skilled private duty respite services,~~] PC for adults, and transition services. DMAS or the [~~prior~~ service]authorization contractor shall perform [~~prior~~service] authorization for [skilled private duty respite services,] AT services and EM services.

6. When a particular service requires [~~prior~~service] authorization, reimbursement shall not be made until the [~~prior~~ service] authorization is secured from either DMAS or the DMAS-designated [~~prior~~service] authorization contractor.

B. Covered services. Covered services shall include: skilled PDN; skilled private duty respite care; [personal care for only adults,] assistive technology; environmental modifications; and transition services only for individuals needing to move from a designated institution into the community or for waiver individuals who have already moved from an institution within 30 days of their transition. Coverage shall not be provided for these services for individuals who reside in any facilities enumerated in 12VAC30-120-1705. Skilled PDN shall be a required service. If an individual has no medical necessity for skilled PDN, he shall not be admitted to this waiver. All other services provided in this waiver shall be provided in conjunction with the provision of skilled PDN.

1. Skilled PDN, for a single individual and congregate group settings, as defined in 12VAC30-120-1700, shall be provided for waiver enrolled individuals who have serious medical conditions or complex health care needs. To receive this service, the individuals must require specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by an RN or an LPN. Upon completion of the required screening and required assessments and a determination that the individual [~~needs~~requires] substantial and ongoing skilled nursing care and waiver enrollment then the PDN hours shall be authorized by the DMAS staff.

a. PDN services shall be rendered according to a POC authorized by DMAS and shall have been certified by a physician as medically necessary to enable the individual to remain at home.

b. No reimbursement shall be provided by DMAS for either RN or LPN services without signed physician orders that specifically identify skilled nursing tasks to be performed for the individual.

c. Limits placed on the amount of PDN that will be approved for reimbursement shall be consistent with the individual's total points on the age-appropriate Tech Waiver Referral Form (DMAS-108) and medical necessity. In no instances shall the individual's POC or ongoing multiple POCs result in coverage of more than 16 hours of PDN in a 24-hour period per household or congregate group setting except for minor individuals during the first 15 calendar days after initial waiver admission [and where 16 scheduled PDN hours are not completed within a 24-hour period, the hours may be re-scheduled and worked within the following 72 hours to support the primary caregiver] .

(1) The number of skilled PDN hours for minor individuals shall be based on the total technology and nursing score on the DMAS Tech Waiver Staff Assessment and updated by the DMAS staff when changes occur and with annual waiver eligibility redetermination by DMAS.

(2) Once the minor individual's composite score (total score) is derived, a LOC is designated for the individual as a Level A, B, or C. This LOC designation determines the maximum number of hours per day of skilled PDN a pediatric individual may have allocated on the DMAS skilled PDN authorization form (Department of Medical Assistance Internal Document). Any hours beyond the maximum for such individual's LOC must be medically necessary and [~~prior~~ service] authorized by DMAS. Any POC submitted without approval for hours beyond the maximum for any particular LOC will only be entered for the maximum for that LOC. The results of the scoring assessment determine the maximum amount of hours available and authorization shall occur as follows:

(a) 50 56 points = 10 hours per day

(b) 57 79 points = 12 hours per day

(c) 80 points or greater = 16 hours per day

(3) For minor individuals, whether living separately or in a congregate setting, during the first 15 calendar days after such individuals' initial admission to the waiver, skilled PDN may be covered for up to 24-hours per day, if [~~needed~~ required] and appropriate to assist the family in adjustment to the care associated with technology assistance. After these first 15 calendar days, skilled PDN shall be reimbursed up to a maximum of 16 hours per 24-hour day period per household [based on the individual's total technology and nursing scores and provided that the aggregate cost-effectiveness standard is not exceeded for the individual's care] .

(4) When reimbursement is to be made for skilled PDN services to be provided in schools, the nurse shall be in the same room as the waiver individual for the hours of skilled PDN care billed. When an individual receives skilled PDN while attending school, the total skilled PDN hours shall not exceed the authorized number of hours under his nursing score category on the Technology Assisted Waiver Pediatric Referral Form (DMAS-109).

(5) The making up or trading of any missed [~~scheduled shifts, days or~~ authorized] hours of care may be done within [~~72 hours~~ the same week (Sunday through Saturday)] of the missed scheduled shift but the total hours made up, including for any day, shall not exceed 16 hours per day for any reason.

(6) For adult individuals, whether living separately or in a congregate group, skilled PDN shall be reimbursed up to a maximum of 16 hours within a 24-hour period per household [based on the individual's total technology and nursing scores and] provided that the [aggregate] cost-effectiveness standard is not exceeded for the individual's care.

(7) The adult individual shall be determined to need a medical device and ongoing skilled nursing care when such individual meets Category A or all eight criteria in Category B:

(a) Category A. Individuals who depend on mechanical ventilators; or

(b) Category B. Individuals who have a complex tracheostomy as defined by:

(i) Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean, with subsequent inability to wean;

(ii) Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;

(iii) Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;

(iv) Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;

(v) Have a physician's order for oxygen therapy with documented usage;

(vi) Receives tracheostomy care at least daily;

(vii) Has a physician's order for tracheostomy suctioning; and

(viii) Deemed at risk to require subsequent mechanical ventilation.

(8) Skilled PDN services shall be available to individuals in their primary residence with some community integration ([~~i.e.,~~ e.g.] medical appointments and school) permitted.

(9) Skilled PDN services may include consultation and training for the primary caregiver.

d. The provider shall be responsible for notifying DMAS should the primary residence of the individual be changed [~~or,~~] should the individual be hospitalized [~~or,~~] should the individual die [, or should the individual be out of the Commonwealth for 48 hours or more] .

e. Exclusions from DMAS' coverage of skilled PDN:

(1) This service shall not be authorized when intermittent skilled nursing visits could be satisfactorily utilized while protecting the health, safety, and welfare of the individual.

(2) Skilled PDN hours shall not be reimbursed while the individual is receiving emergency care or during emergency transport of the individual to such facilities. The RN or LPN shall not transport the waiver individual to such facilities.

(3) Skilled PDN services may be ordered but shall not be provided simultaneously with PDN respite care or personal care services as described in 12VAC30-120-1720.

(4) Parents (natural, adoptive, legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide skilled PDN services for the purpose of Medicaid reimbursement for the waiver individual.

(5) Providers shall not bill prior to receiving the physician's dated signature on the individual's POC for services provided and the DMAS staff's authorization/determination of skilled PDN hours.

(6) Time spent driving the waiver individual shall not be reimbursed by DMAS.

f. Congregate skilled PDN.

(1) If more than one waiver individual will reside in the home, the same waiver provider or providers shall be chosen to provide all skilled PDN services for all waiver individuals in the home.

(2) Only one nurse shall be authorized to care for [~~each~~no more than] two waiver individuals in such arrangements. In instances when three waiver individuals share a home, nursing ratios shall be determined by DMAS or its designated agent based on the needs of all the individuals who are living together. These congregate skilled PDN hours shall be at the same scheduled shifts.

(3) The primary caregiver shall be shared and shall be responsible for providing at least eight hours of skilled PDN care per 24 hours as well as all skilled PDN care needs in the absence of the provider agency.

(4) DMAS shall not reimburse for skilled PDN services through the tech waiver and skilled PDN services through the EPSDT benefit for the same individual at the same time.

2. Skilled private duty respite care services. Skilled private duty respite care services may be covered for a maximum of [~~240~~ 360] hours per calendar year regardless of waiver for individuals who are qualified for tech waiver services and regardless of whether the waiver individual changes waivers and who have [~~an~~ a] primary caregiver who requires temporary or intermittent relief from the burden of care giving.

a. This service shall be provided by skilled nursing staff licensed to practice in the Commonwealth under the direct supervision of a [licensed certified or

accredited] home health agency [~~licensed certified or accredited~~] and with which DMAS has a provider agreement to provide skilled PDN.

b. Skilled private duty respite care services shall be comprised of both skilled and hands-on care of either a supportive or health-related nature and may include, but shall not be limited to, all skilled nursing care as ordered on the physician-certified POC, assistance with [~~ADLs~~ADLs/IADLs], administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual or individuals.

c. When skilled private duty respite services are offered in conjunction with skilled PDN, the same individual record may be used with a separate section for skilled private duty respite services documentation.

d. Individuals who are living in congregate arrangements shall be permitted to share skilled private duty respite care service providers. The same limits on this service in the congregate setting ([~~240~~ 360] hours per calendar year per household) shall apply regardless of the waiver.

e. Skilled private duty respite care services shall be provided in the individual's primary residence as is designated upon admission to the waiver.

3. Assistive technology services. Assistive technology, as defined in 12VAC30-120 -1700, devices [~~must~~ shall] be portable and shall be authorized per calendar year.

a. AT services shall be available for enrolled waiver individuals who are receiving skilled PDN [. ~~and~~ AT services] are the specialized medical equipment and supplies, including those devices, controls, or appliances, specified in the individual's plan of care, but that are not available under the State Plan for Medical Assistance, that enable waiver individuals to increase their abilities to perform [~~ADLs~~ ADLs/IADLs], or to perceive, control, or communicate with the environment in which they live. This service includes ancillary supplies, and equipment necessary to the proper functioning of such items.

b. An independent, professional consultation [~~must~~shall] be obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by DMAS or the designated [~~prior~~ service] authorization contractor. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists. A prescription shall not meet the standard of an assessment.

c. In order to qualify for these services, the individual must have a demonstrated need for equipment for remedial or direct medical benefit primarily in the individual's primary residence or primary vehicle to specifically serve to improve the individual's personal functioning.

d. AT shall be covered in the least expensive, most cost-effective manner. The cost of AT services shall be included in the total cost of waiver services.

e. Service units and service limitations. AT equipment and supplies shall not be rented but shall be purchased through a Medicaid-enrolled durable medical equipment provider.

(1) The service unit is always one, for the total cost of all AT being requested for a specific timeframe. The maximum Medicaid-funded expenditure per individual for all AT covered procedure codes combined shall be [~~pursuant to 12VAC30-120-762~~ $5,000 per individual per calendar year] .

(2) The cost for AT shall not be carried over from one calendar year to the next. Each item must be [~~prior~~service] authorized by either DMAS or the DMAS designated contractor for each calendar year.

(3) Unexpended portions of the maximum amount shall not be accumulated across one or more calendar years to be expended in a later year.

(4) Shipping/freight/delivery charges are not billable to DMAS or the waiver individual, as such charges are considered noncovered items.

(5) All products must be delivered, demonstrated, installed and in working order prior to submitting any claim for them to Medicaid.

(6) The date of service on the claim [~~must~~shall] be within the [~~prior~~ service] authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.

(7) The [~~prior~~ service]authorization shall not be modified to accommodate delays in product deliveries. In such situations, new [~~prior~~ service]authorizations must be sought by the provider.

(8) When two or more waiver individuals live in the same home or congregate living arrangement, the AT shall be shared to the extent practicable consistent with the type of AT.

f. AT exclusions.

(1) Medicaid shall not reimburse for any AT devices or services that may have been rendered prior to authorization from DMAS or the designated [~~prior~~ service] authorization contractor.

(2) Providers of AT shall not be spouses, parents (natural, adoptive, or foster), or stepparents of the individual who is receiving waiver services. Providers that supply AT for the waiver individual may not perform assessments/consultation or write specifications for that individual. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and [~~prior~~service] authorization by DMAS or the designated [~~prior~~service] authorization contractor. The vendor [~~must~~shall] receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary then the vendor [~~must~~ shall] notify the assessor to ensure the changed items meet the individual's needs.

(3) All equipment or supplies already covered by a service provided for in the State Plan shall not be purchased under the waiver as AT. Such examples are, but shall not necessarily be limited to:

(a) Specialized medical equipment, durable or nondurable medical equipment (DME), ancillary equipment, and supplies necessary for life support;

(b) Adaptive devices, appliances, and controls that enable an individual to be more independent in areas of personal care and [~~ADLs~~ ADLs/IADLs], and;

(c) Equipment and devices that enable an individual to communicate more effectively.

(4) AT services shall not be approved for purposes of the convenience of the caregiver, restraint of the individual, recreation or leisure, educational purposes, or diversion activities. Examples of these types of items shall be listed in DMAS guidance documents.

4. Environmental modifications services shall be covered as defined in 12VAC30-120-1700. Medicaid reimbursement shall not occur before [~~prior~~service] authorization of EM services is completed by DMAS or the DMAS-designated

[~~prior~~ service] authorization contractor. EM services shall entail limited physical adaptations to preexisting structures and shall not include new additions to an existing structure that simply increase the structure's square footage.

a. In order to qualify for EM services, the individual [~~must~~shall]have a demonstrated need for modifications of a remedial nature or medical benefit to the primary residence to specifically improve the individual's personal functioning. Such modifications may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways and other adaptations to accommodate wheelchairs, modification of bathroom facilities to accommodate wheelchairs (but not strictly for cosmetic purposes), or installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies that are necessary for the individual's welfare. Modifications may include a generator for waiver individuals who are dependent on mechanical ventilation for 24-hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare.

b. EM shall be available costing up to a maximum amount of $5,000 per calendar year regardless of waiver for individuals who are receiving skilled PDN services. [~~Effective January 1, 2011, the maximum Medicaid-funded expenditure per individual for all EM-covered procedure codes combined shall be pursuant to 12VAC30-120-758.~~]

c. Costs for EM shall not be carried over from one calendar year to the next year. Each item shall be [~~prior~~service] authorized by DMAS or the DMAS-designated agent for each calendar year. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year.

d. When two or more waiver individuals live in the same home or congregate living arrangement, the EM shall be shared to the extent practicable consistent with the type of requested modification.

e. Only the actual cost of material and labor is reimbursed. There shall be no additional markup.

f. EM shall be carried out in the most cost-effective manner possible to achieve the goal required for the individual's health, safety, and welfare. The cost of EM waiver services shall be included in the individual's costs of all other waiver services, which shall not exceed the total annual cost for placement in an institution.

g. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections which shall be provided to DMAS or the DMAS contractor.

h. Proposed modifications that are to be made to rental properties must have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.

i. Modifications may be made to a vehicle if it is the primary vehicle used by the individual. This service shall not include the purchase of or the general repair of vehicles. [Repairs of modifications which have been reimbursed by DMAS shall be covered.]

j. The EM provider shall ensure that all work and products are delivered, installed, and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the [~~prior~~ service] authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates. The [~~prior~~service] authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to DMAS or the DMAS-

designated [~~prior~~service] authorization contractor for revision to the previously issued [~~prior~~ service] authorization and [~~must~~ shall] include justification and supporting documentation of medical needs.

k. EM exclusions.

(1) There shall be no duplication of [previous]EM services [~~with~~ within] the same residence such as multiple wheelchair ramps or [~~multiple~~previous] modifications to the same room. [There shall be no duplication of EM within the same plan year.]

(2) Adaptations or improvements to the primary home that shall be excluded are of general utility and are not of direct medical or remedial benefit to the waiver individual, such as, but not necessarily limited to, carpeting, flooring, roof repairs, central air conditioning or heating, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement or addition of sidewalks, driveways, carports, or adaptations that only increase the total square footage of the home.

(3) EM shall not be covered by Medicaid for general leisure or diversion items or those items that are recreational in nature or those items that may be used as an outlet for adaptive/maladaptive behavioral issues. Such noncovered items may include, but shall not necessarily be limited to, swing sets, playhouses, climbing walls, trampolines, protective matting or ground cover, sporting equipment or exercise equipment, such as special bicycles or tricycles.

(4) EM shall not be approved for Medicaid coverage when the waiver individual resides in a residential provider's facility program, such as sponsored homes and congregate residential and supported living settings. EM shall not be covered by Medicaid if, for example, the Fair Housing Act (42 USC § 3601 et seq.), the Virginia Fair Housing Law (§ 36-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.) requires the modification and the payment for such modifications [are] to be made by a third party.

(5) EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.

(6) Providers of EM shall not be the waiver individual's spouse, parent (natural, adoptive, legal guardians), other legal guardians, or conservator. Providers who supply EM to waiver individuals shall not perform assessments/consultations or write EM specifications for such individuals.

5. Personal care services as defined in 12VAC30-120-1700, shall be covered for individuals older than 21 years of age who have a demonstrated need for assistance with ADLs and IADLs and who have a trained primary caregiver for skilled PDN interventions during portions of their day. PC services shall be rendered by a provider who has a DMAS provider agreement to provide PC, home health care, or skilled PDN. Due to the complex medical needs of this waiver population and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and rendering the required skilled services during the entire time that the PCA is providing nonskilled care.

a. PC services are either of a supportive or health-related nature and may include, but are not limited to, assistance with [~~ADLs~~ ADLs/IADLs], community access (such as, but not necessarily limited to, going to medical appointments), monitoring of self-administration of medication or other medical needs, and monitoring of health status and physical condition. In order to receive PC, the individual must require assistance with [~~ADLs~~ ADLs/IADLs]. When specified in the POC, PC services may also include assistance with IADLs to include making or changing beds, and cleaning areas used by the individual. Assistance with

IADLs must be essential to the health and welfare of the individual, rather than the individual's representative, as applicable.

(1) The unit of service for PC services shall be one hour. The hours that may be authorized by DMAS or the designated [~~prior~~service] authorization contractor shall be based on the individual's need as documented in the individual's POC and assessed on the Technology Assisted Waiver Adult Aide Plan of Care (DMAS-97 T).

(2) Supervision of the waiver individual shall not be covered as part of the tech waiver personal care service.

(3) Individuals may have skilled PDN, PC, and skilled private duty nursing respite care in their plans of care but shall not be authorized to receive these services simultaneously.

b. PC services shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate, with the exception of skilled nursing tasks that may be delegated in accordance with Part VIII (18VAC90-20-420 et seq.). The PCA may perform ADL functions such as assistance to the primary caregiver but shall not perform any nursing duties or roles except as permitted by Part VIII (18VAC90-20-420 et seq.). At a minimum, the staff providing PC must have been certified through coursework as either PCAs or home health aides.

c. DMAS will pay for any PC services that the PC aide gives to individuals to assist them in preparing for school or when they return home. DMAS shall not pay for the PC aide to assist the individual with any functions related to the individual completing post-secondary school functions or for supervision time during school.

d. PC exclusions.

(1) Time spent driving the waiver individual shall not be reimbursed.

(2) Regardless of the combination of skilled PDN and PC hours, the total combined number of hours that shall be reimbursed by DMAS in a 24-hour day shall not exceed 16 hours.

(3) The consumer-directed services model shall not be covered for any services provided in the tech waiver.

(4) Spouses, parents (natural, adoptive, legal guardians), siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide PC services for the purpose of Medicaid reimbursement for the waiver individual.

6. Transition services shall be covered two ways: (i) as defined at 12VAC30-120-1700 to provide for applicants to move from institutional placements to community private homes and shall be [~~prior~~service] authorized by DMAS or the designated [~~prior~~service] authorization contractor in order for reimbursement to occur, and (ii) for applicants who have already moved from an institution to the community within 30 days of their transition. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall coordinate with the DMAS staff to ensure that technology assisted waiver eligibility criteria shall be met.

a. Transition services shall be [~~prior~~service] authorized by DMAS or its designated [~~prior~~service] authorization contractor in order for reimbursement to occur. These services shall include those set out in the MFP [~~program~~demonstration] .

b. For the purposes of transition funding [for the Technology Assisted Waiver] , an institution means an [~~ICF/MR~~ICF/ID] , a specialized care nursing facility or a long-stay hospital as defined at 42 CFR 435.1009. Transition funding shall not be available for individuals who have been admitted to an acute care hospital.

c. When the Money Follows the Person demonstration [~~waiver grant~~] is terminated [or expires]by federal action, the portion of this service covered through MFP shall also terminate. The remaining transition services shall continue until modified.

C. Changes to services or termination of services.

1. DMAS or its designated agent shall have the final authority to approve or deny a requested change to an individual's skilled PDN and PC hours. Any request for an increase to an individual's skilled PDN or PC hours that exceeds the number of hours allowed for that individual's LOC shall be [~~prior~~ service] authorized by DMAS staff and accompanied by adequate documentation justifying the increase.

a. The provider may decrease the amount of authorized care if the revised skilled PDN hours are appropriate and based on the needs of the individual. The provider agency shall work with the DMAS staff for coordination and final approval of any decrease in service delivery. A revised tech waiver skilled PDN authorization shall be completed by DMAS for final authorization and forwarded to the provider agency.

b. The provider shall be responsible for documenting in writing the physician's verbal orders and for inclusion of the changes on the recertification POC in accordance with the DMAS skilled PDN Authorization Form. The provider agency's RN supervisor, who is responsible for supervising the individual's care, shall use a person-centered approach in discussing the change in care with the individual and individual representative to include documentation in the individual's record. The DMAS staff or the DMAS designated[~~prior~~ service] authorization contractor shall notify in writing the individual or individual representative of the change.

c. The provider shall be responsible for submitting the DMAS-225 form to the local department of social services when the following situations occur: (i) when Medicaid eligibility status changes; (ii) when the individual's level of care changes; (iii) when the individual is admitted to or discharged from an institution, a home and community-based waiver, or a provider agency's care; (iv) the individual dies; or (v) any other information that causes a change in the individual's eligibility status or patient pay amounts.

2. At any time the individual no longer meets LOC criteria for the waiver, termination of waiver enrollment shall be initiated by DMAS staff who is assigned to the individual. In such instances, DMAS shall forward the DMAS-225 form to the local department of social services.

3. In an emergency situation when the health, safety, and welfare of the provider staff is endangered, the provider agency may immediately initiate discharge of the individual and contact the DMAS staff. The provider must issue written notification containing the reasons for and the effective date of the termination of services. The written notification period in subdivision 4 of this subsection shall not be required. Other entities (e.g., licensing authorities, APS, CPS) shall also be notified as appropriate. A copy of this letter shall be forwarded to the DMAS staff within five business days of the letter's date.

4. In a nonemergency situation (i.e., when the health, safety, or welfare of the waiver individual or provider personnel are not endangered), the provider shall provide the individual and [the~~individual~~ individuals] representative 14 calendar days' written notification (plus three days to allow for mail transmission) of the

intent to discharge the individual from agency services. Written notification shall provide the reasons for and the effective date of the termination of services as well as the individual's appeal rights. A copy of the written notification shall also be forwarded to the DMAS staff within five business days of the date of the notification.

5. Individuals who no longer meet the tech waiver criteria as certified by the physician for either children or adults shall be terminated from the waiver. In such cases, a reduction in skilled PDN hours may occur that shall not exceed two weeks in duration as long as such skilled PDN was previously approved in the individual's POC. The agency provider of skilled PDN for such individuals shall document with DMAS the decrease in skilled PDN hours and prepare for cessation of skilled PDN hours and waiver services.

6. When a waiver individual, regardless of age, requires admission to a specialized care nursing facility or long-stay hospital, the individual shall be discharged from waiver services while he is in the specialized care nursing facility or long-stay hospital. Readmission to waiver services may resume once the individual has been discharged from the specialized care nursing facility or long-stay hospital as [~~alonglong~~] as the waiver eligibility and medical necessity criteria continue to be met. For individuals 21 years of age and older, the individual [~~must~~ shall] follow the criteria for specialized care nursing facility admission. For individuals who are younger than 21 years of age, the individual [~~must~~ shall] follow the criteria for long-stay hospital admissions as well as the age appropriate criteria.

7. When a waiver individual, regardless of age, requires admission to a [~~rehabilitation]~~ hospital, the individual shall be discharged from waiver services while he is in the [~~rehabilitation~~] hospital. When such [~~rehabilitation~~] hospitalization exceeds 30 days, readmission to waiver services requires a reassessment by the PAS team for determination that the individual currently meets Medicaid eligibility, functional criteria, and specialized nursing facility waiver criteria. If these criteria are met, the individual shall be readmitted to waiver services. For adults, ages 21 years and older, the individual shall meet the criteria for specialized care admissions. For children, younger than 21 years of age, the individual shall meet the criteria for long-stay hospital admissions and the age appropriate criteria.

8. Waiver individuals, regardless of age, who require admission to any type of acute care facility for less than 30 days shall, upon discharge from such acute care facility, be eligible for waiver services as long as all other requirements continue to be met.

12VAC30-120-1730
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-1730. General requirements for participating providers.

A. All agency providers shall sign the appropriate technology assisted waiver provider agreement in order to bill and receive Medicaid payment for services rendered. Requests for provider enrollment shall be reviewed by DMAS to determine whether the provider applicant meets the requirements for Medicaid participation and demonstrates the abilities to perform, at a minimum, the following activities:

1. Be able to render the medically necessary services required by the waiver individuals. Accept referrals for services only when staff is available and qualified to initiate and perform the required services on an ongoing basis;

2. Assure the individual's freedom to reject medical care and treatment;

3. Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service or services that may be required and participating in the Medicaid program at the time the service or services are performed;

4. Actively involve the individual and the authorized representative, as applicable, in the assessment of needs, strengths, goals, preferences, and abilities and incorporate this information into the person-centered planning process. A provider shall protect and promote the rights of each individual for whom he is providing services and shall provide for each of the following individual rights:

a. The individual's rights are exercised by the person appointed under state law to act on the individual's behalf in the case of an individual adjudged incompetent under the laws of the Commonwealth by a court of competent jurisdiction,

b. The individual, who has not been adjudged incompetent by the state court, may designate any legal-surrogate in accordance with state law to exercise the individual's rights to the extent provided by state law.

c. The individual shall have the right to receive services from the provider with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other waiver individuals would be endangered.

5. Perform a criminal background check [~~and sex offender registry checks~~] on all employees, including the business owner, who may have any contact or provide services to the waiver individual. Such record checks shall [~~include national searches as well as with~~ be performed by] the Virginia State Police for the Commonwealth. [~~Searches~~ When the Medicaid individual is a minor child, searches] shall also be made of the Virginia CPS Central Registry, [~~adult protective services, the National Sex Offender Registry, and the Virginia Nurse Aide Registry~~] .

a. Provider documentation of the results of these searches must be made available upon request of DMAS or its authorized representatives. Persons convicted of having committed barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia shall not render services to waiver individuals for the purposes of seeking Medicaid reimbursement.

b. Persons having founded dispositions in the CPS Central Registry at DSS shall not be permitted to render services to children in this waiver and seek Medicaid reimbursement. Medicaid reimbursement shall not be made for providers' employees who have findings [~~in the Nurse Aide Registry~~] with the Virginia Board of Nursing of the Department of Health Professions concerning abuse, neglect, or mistreatment of individuals or misappropriation of their property.

6. Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in federal programs. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and entities to validate the eligibility of such persons and entities for federal programs.

a. Immediately report to DMAS any exclusion information identified.

b. Such information shall be sent in writing and shall include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date.

c. Such information shall be sent to: DMAS, ATTN: Program Integrity/Exclusions, 600 E. Broad St., Suite 1300, Richmond, VA 23219 or emailed to providerexclusion@dmas.virginia.gov.

7. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000 et seq.), which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the ADA of 1990, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities.

8. Report all suspected violations, pursuant to [§ 63.2-100,] § 63.2-1606 et seq. and §§ 63.2-1508 through 63.2-1513 of the Code of Virginia, involving mistreatment, neglect, or abuse, including injuries of an unknown source, and misappropriation of individual property to either CPS, APS, or other officials in accordance with state law. Providers shall also train their staff in recognizing all types of such injuries and how to report them to the appropriate authorities. Providers shall ensure that all employees are aware of the requirements to immediately report such suspected abuse, neglect, or exploitation to APS, CPS or human rights, as appropriate.

9. Notify DMAS or its designated agent immediately, in writing, of any change in the information that the provider previously submitted to DMAS. When ownership of the provider changes, notify DMAS at least 15 calendar days before the date of such a change;

10. Provide services and supplies to individuals in full compliance of the same quality and in the same mode of delivery as are provided to the general public. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public.

11. Accept as payment in full the amount established and reimbursed by DMAS' payment methodology beginning with individuals' authorization dates for the waiver services. The provider shall not attempt to collect from the individual or the individual's responsible relative or relatives any amount the provider may consider a balance due amount or an uncovered amount. Providers shall not collect balance due amounts from individuals or individuals' responsible relatives even if such persons are willing to pay such amounts. Providers shall not bill DMAS, individuals or their responsible relatives for broken or missed appointments.

12. Collect all applicable patient pay amounts pursuant to 12VAC30-40-20, 12VAC30-40-30, 12VAC30-40-40, 12VAC30-40-50, and 12VAC30-40-60.

13. Use only DMAS-designated forms for service documentation. The provider shall not alter the required DMAS forms in any manner unless DMAS' approval is obtained prior to using the altered forms.

14. Not perform any type of direct-marketing activities to Medicaid individuals.

15. Furnish access to [the records of] individuals who are receiving Medicaid services and furnish information, on request and in the form requested, to DMAS or its designated agent or agents, the Attorney General of Virginia or his authorized representatives, the state Medicaid Fraud Control Unit, the State Long-Term Care Ombudsman and any other authorized state and federal personnel. The Commonwealth's right of access to individuals receiving services and to provider agencies and records shall survive any termination of the provider agreement.

16. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, and business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of services to participants of Medicaid.

17. Pursuant to 42 CFR 431.300 et seq. and § 32.1-325.3 of the Code of Virginia, all information associated with [~~ana~~ waiver] applicant or [~~recipient~~ individual] that could disclose the individual's identity is confidential and shall be safeguarded. Access to information concerning [waiver]applicants or [~~recipients~~ individuals] [~~must~~ shall] be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency, and any such access must be in accordance with the provisions found in 12VAC30-20-90.

18. Meet staffing, financial solvency, disclosure of ownership, assurance of comparability of services requirements, and other requirements as specified in the provider contract (Medical Assistance Program Participation Agreement).

19. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided fully and accurately with documentation necessary to support services billed. Failure to meet this requirement may result in DMAS' recovery of expenditures resulting from claims payment.

20. Maintain a medical record for each individual who is receiving waiver services. Failure to meet this requirement may result in DMAS recovering expenditures made for claims paid that are not adequately supported by the provider's documentation.

21. Retain business and professional records at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth.

22. Retain records of minors for at least six years after such [~~minor has~~ minors have] reached [~~18~~ 21] years of age.

23. Ensure that all documentation in the individual's record is completed, signed, and dated with the name or names of the person or persons providing the service and the appropriate title, dated with month, day, and year, and in accordance with accepted professional practice. This documentation shall include the nurses' or PCAs', as appropriate, arrival and departure times for each shift that is worked.

24. Begin PDN services for which it expects reimbursement only when the admission packet is received and DMAS' authorization for skilled PDN services has been given. This authorization shall include the enrollment date that [~~must~~ shall] be issued by DMAS staff. It shall be the provider agency's responsibility to review and ensure the receipt of a complete and accurate screening packet.

25. Ensure that there is a backup caregiver who accepts responsibility for the oversight and care of the individual in order to [~~assure~~ensure] the health, safety, and welfare of the individual when the primary caregiver is ill, incapacitated, or using PDN respite. Documentation in the medical record [~~must~~ shall]include this backup caregiver's name and phone number.

26. Notify the DMAS staff every time the waiver individual's primary residence changes.

27. Ensure that minimum qualifications of provider staff are met as follows:

a. All [RN and LPN] employees shall have a satisfactory work record, as evidenced by at least two references from prior job experiences. In lieu of this

requirement [for personal care aides only] , employees who have [~~only~~] worked for [only] one employer shall be permitted to provide two personal references. [Providers who are not able to obtain previous job references about personal care aides shall retain written documentation showing their good faith efforts to obtain such references in the new employee's work record.]

b. Staff and agencies shall meet any certifications, licensure, or registration, as applicable and as required by applicable state law. Staff qualifications [~~must~~ shall] be documented and maintained for review by DMAS or its designated agent. All additional provider requirements as may be required under a specific waiver service in this part [~~must~~ shall] also be met.

c. In addition, the RN as well as all nurses providing the skilled PDN service shall be currently and validly licensed to practice nursing in the Commonwealth and have at least six months of related clinical experience which may include work in acute care hospitals, long-stay hospitals, rehabilitative hospitals or specialized care nursing facilities. The LPN shall be under the direct supervision of an RN.

d. The RN supervisor shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility.

B. DMAS shall have the authority to require the submission of any other medical documentation or information as may be required to complete a decision for a waiver individual's eligibility, waiver enrollment, or coverage for services.

1. Review of individual-specific documentation shall be conducted by DMAS or its designated agent. This documentation shall contain, up to and including the last date of service, all of the following, as may be appropriate for the service rendered:

a. All supporting documentation, including physicians' orders, from any provider rendering waiver services for the individual;

b. All assessments, reassessments, and evaluations (including the complete UAI screening packet or risk evaluations) made during the provision of services, including any required initial assessments by the RN supervisor completed prior to or on the date services are initiated and changes to the supporting documentation by the RN supervisor;

c. Progress notes reflecting individual's status and, as appropriate, progress toward the identified goals on the POC;

d. All related communication with the individual and the family/caregiver, the designated agent for [~~prior~~service] authorization, consultants, DMAS, DSS, formal and informal service providers, referral to APS or CPS and all other professionals concerning the individual, as appropriate.

e. [~~Prior~~ Service]-authorization decisions performed by the DMAS staff or the DMAS-designated [~~prior~~service] authorization contractor;

f. All POCs completed for the individual and specific to the service being provided and all supporting documentation related to any changes in the POCs; and

g. Attendance logs documenting the date and times services were rendered, the amount and type of services rendered and the dated professional signature with title.

2. Review of provider participation standards and renewal of provider agreements. DMAS shall be responsible for [~~assuring~~ ensuring] continued adherence to provider participation standards by conducting ongoing monitoring of compliance.

a. DMAS shall recertify each provider for agreement renewal, contingent upon the provider's timely license renewal, to provide home and community-based waiver services.

b. A provider's noncompliance with DMAS policies and procedures, as required in the provider agreement, may result in a written request from DMAS for a corrective action plan that details the steps the provider shall take and the length of time required to achieve full compliance with the corrective action plan which shall correct the cited deficiencies.

c. [~~DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation.~~] A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories must, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. [Upon such notice, DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 D of the Code of Virginia and as may be required for federal financial participation.] Such provider agreement terminations shall be immediate and conform to [~~12VAC30-10-690 and 12VAC30-20-491~~ § 32.1-325 E of the Code of Virginia] .

d. Providers shall not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction.

e. Except as otherwise provided by applicable state or federal law, the Medicaid provider agreement may be terminated at will on 30 days' written notice. The agreement may be terminated if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program.

12VAC30-120-1740
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-1740. Participation standards for provision of services.

A. Skilled PDN, skilled PDN respite, and PC services. DMAS or its designated agent shall periodically review and audit providers' records for these services for conformance to regulations and policies, and concurrence with claims that have been submitted for payment. When an individual is receiving multiple services, the records for all services shall be separated from those of non [-] home and community-based care services, such as companion or home health services. The following documentation [~~must~~ shall] be maintained for every individual for whom DMAS-enrolled providers render these services:

1. Physicians' orders for these services shall be maintained in the individual's record as well as at the individual's primary residence. All recertifications of the POC [~~must~~ shall]be performed within the last five business days of each current 60-day period. The physician shall sign the recertification before Medicaid reimbursement shall occur;

2. All assessments, reassessments, and evaluations (including the complete UAI screening packet or risk evaluations) made during the provision of services, including any required initial assessments by the RN supervisor completed prior to or on the date services are initiated and changes to the supporting documentation by the RN supervisor;

3. Progress notes reflecting individual's status and, as appropriate, progress toward the identified goals on the POC;

4. All related communication with the individual and the individual representative, the DMAS designated agent for [~~prior~~service] authorization, consultants, DMAS, DSS, formal and informal service providers, all required referrals, as appropriate, to APS or CPS and all other professionals concerning the individual;

5. All [~~prior~~ service] authorization decisions rendered by the DMAS staff or the DMAS-designated [~~prior~~service] authorization contractor;

6. All POCs completed with the individual, or family/caregiver, as appropriate, and specific to the service being provided and all supporting documentation related to any changes in the POC;

7. Attendance logs documenting the date and times services were rendered, the amount and type of services rendered and the dated signatures of the professionals who rendered the specified care, with the professionals' titles. Copies of all nurses' records shall be subject to review by either state or federal Medicaid representatives or both. Any required nurses' visit notes, PCA notes, and all dated contacts with service providers and during supervisory visits to the individual's home and shall include:

a. The private duty nurse's or PCA's daily visit note with arrival and departure times;

b. The RN, LPN, or PCA daily observations, care, and services that have been rendered, observations concerning the individual's physical and emotional condition, daily activities and the individual's response to service delivery; and

c. Observations about any other services, such as and not limited to meals-on-wheels, companion services, and home health services, that the participant may be receiving shall be recorded in these notes.

8. Provider's HIPAA release of information form;

9. All Long Term Care Communication forms (DMAS-225);

10. Documentation of rejection or refusal of services and potential outcomes resulting from the refusal of services communicated to the individual or the individual representative;

11. Documentation of all inpatient hospital or specialized care nursing facility admissions to include service interruption dates, the reason for the hospital or specialized care nursing facility admission, the name of the facility or facilities and primary caregiver notification when applicable including all communication to DMAS;

12. The RN, LPN, or PCA's and individual's, or individual's representative's weekly or daily, as appropriate, signatures, including the date, to verify that services have been rendered during that week as documented in the record. [For records requiring weekly signatures, such signatures, times, and dates shall be placed on these records no earlier than the last day of the week in which services were provided and no later than seven calendar days from the date of the last service.] An employee providing services to the Tech Waiver individual cannot sign for the individual. If the individual is unable to sign the nurses' records, it [~~must~~shall] be documented in the record how or who will sign in the individual's place. An employee of the provider shall not sign for the individual unless he is a family member of the individual or legal guardian of the individual;

13. Contact notes or progress notes reflecting the individual's status; and

14. Any other documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

B. In addition to meeting the general conditions and requirements for home and community-based services participating providers and PDN, [private duty] respite, and PC services, providers [~~must~~ shall] also meet the following requirements:

1. This service shall be provided through either a home health agency licensed or certified by the VDH for Medicaid participation and with which DMAS has a contract for either skilled PDN or congregate PDN or both;

2. Demonstrate a prior successful health care delivery;

3. Operate from a business office; and

4. Employ (or subcontract with) and directly supervise an RN or an LPN. The LPN and RN shall be currently licensed to practice in the Commonwealth and have at least six months of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility.

5. As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 days to ensure both quality and appropriateness of PDN [~~and~~ ,] PDN respite services, [and personal care services] to assess the individual's and individual representative's satisfaction with the services being provided, to review the medication and treatments and to update and verify the most current physician signed orders are in the home.

a. The waiver individual shall be present when the supervisory visits are made;

b. At least every other visit shall be in the individual's primary residence;

c. When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay [~~must~~shall] be documented in the individual's record, and the visit shall occur as soon as the individual is available. Failure to meet this standard may result in DMAS' recovery of payments made.

[d. The RN supervisor may delegate personal care aide supervisory visits to an LPN. The provider's RN or LPN supervisor shall make supervisory visits at least every 90 days. During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the individual's current functioning status and medical and social needs. The personal care aide's record shall be reviewed and the waiver individual's or family/caregiver's, or both, satisfaction with the type and amount of services discussed.]

[~~d~~ e] . Additional supervisory visits may be required under the following circumstances: (i) at the provider's discretion; (ii) at the request of the individual when a change in the individual's condition has occurred; (iii) any time the health, safety, or welfare of the individual could be at risk; and (iv) at the request of the DMAS staff.

6. When [private duty] respite services are routine in nature and offered in conjunction with PC services [for adults] , the RN supervisory visit conducted for PC may serve as the supervisory visit for respite services. However, the supervisor [~~must~~ shall] document supervision of [private duty] respite services separately. For this purpose, the same individual record can be used with a separate section for [private duty] respite services documentation.

7. For this waiver, personal care services shall only be agency directed and provided by a DMAS-enrolled PC provider [to adult waiver individuals] .

a. For DMAS-enrolled skilled PDN providers that also provide PC services, the provider shall employ or subcontract with and directly supervise an RN who will

provide ongoing supervision of all PCAs. The supervising RN shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility.

b. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified elsewhere in this part, the provision of PC services shall also comply with the requirements of 12VAC30-120-930.

8. Skilled monthly supervisory reassessments shall be performed in accordance with regulations by the PDN agency provider. The agency RN supervisor shall complete the monthly assessment visit and submit the "Technology Assisted Waiver Supervisory Monthly Summary" form (DMAS-103) to DMAS for review by the sixth day of the month following the month when the visit occurred.

9. Failure of the provider to [~~assure~~ ensure] timely submission of the required assessments may result in retraction of all skilled PDN payments for the period of time of the delinquency.

C. Assistive technology and environmental modification.

1. All AT and EM services shall be provided by DMAS-enrolled DME providers who have a DMAS provider agreement to provide AT or EM [or both] .

2. AT and EM shall be covered in the least expensive, most cost-effective manner. The provider [~~must~~ shall]document and justify why more cost-effective solutions cannot be used. DMAS and the DMAS-designated [~~prior~~ service] authorization contractor may request further documentation on the alternative cost-effective solutions as necessary.

3. The provider documentation requirements for AT and EM shall be as follows:

a. Written documentation setting out the medical necessity for these services regarding the need for service, the process and results of ensuring that the item is not covered by the State Plan as DME and supplies and that it is not available from a DME provider when purchased elsewhere and contacts with vendors or contractors of service and cost;

b. Documentation of any or all of the evaluation, design, labor costs or supplies by a qualified professional;

c. Documentation of the date services are rendered and the amount of service needed;

d. Any other relevant information regarding the device or modification;

e. Documentation in the medical record of notification by the designated individual or individual representative of satisfactory completion or receipt of the service or item;

f. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed; and

g. Any additional cost estimates requested by DMAS.

7. The EM/AT provider shall maintain a copy of all building permits and all building inspections for modifications, as required by code. All instructions regarding any warranty, repairs, complaints, and servicing that may be needed and the receipt for any purchased goods or services. More than one cost estimate may be required.

8. Individuals who reside in rental property [~~mustshall~~] obtain written permission from the property's owner before any EM shall be authorized by DMAS. This letter shall be maintained in the provider's record.

12VAC30-120-1750
12VAC30-120-1750. Payment for services.

A. [~~All skilled PDN services, skilled PDN respite care services, and~~] PC services provided in the tech waiver shall be reimbursed at an hourly rate established by DMAS. All skilled PDN services and skilled PDN respite care services shall be reimbursed in increments of 15 minutes as a unit and shall be reimbursed at a rate established by DMAS.]

B. Reimbursement for AT and EM shall be as follows.

1. All AT covered procedure codes provided in the tech waiver shall be reimbursed as a service limit of one and up to a per member annual maximum of $5,000 per calendar year regardless of waiver. Such service shall only be provided to individuals who are also receiving private duty nursing.

2. All EM services shall be reimbursed up to $5,000 per individual per calendar regardless of waiver year as long as such services are not duplicative. All EM services shall be reimbursed at the actual cost of material and labor and no mark ups shall be permitted. Such service shall only be provided to individuals who are also receiving private duty nursing.

C. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973 (29 USC 791 et seq.), or the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia).

2. Payment for services under the POC shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. All private insurance benefits for skilled PDN shall be exhausted before Medicaid reimbursement can occur as Medicaid shall be the payer of last resort.

3. DMAS payments for EM shall not be duplicative in homes where multiple waiver individuals reside. For example, one waiver individual may be approved for required medically necessary bathroom modifications while a second waiver individual in the same household would be approved for a medically necessary access ramp but not [~~additional~~ for the same] improvements to the same bathroom.

D. Cost-effectiveness computations for the tech waiver shall be completed by DMAS upon completion of the POC for all individuals entering the waiver. The total annual aggregate cost of the waiver shall not exceed the cost of backup facility placement. For individuals, regardless of age, the DMAS staff shall ensure the anticipated cost to DMAS for the individual's waiver services for a 12-month period shall not exceed the annual average aggregate costs to DMAS for specialized nursing facility care for those individual's 21 years of age or older or for continued hospitalization for individuals younger than 21 years of age.

12VAC30-120-1760
12VAC30-120-1760. Quality management review; utilization reviews; level of care (LOC) reviews.

A. DMAS shall perform quality management reviews for the purpose of [~~assuring~~ ensuring] high quality of service delivery consistent with the attending physicians' orders, approved POCs, and [~~prior~~ service] authorized services for the waiver individuals. Providers identified as not rendering reimbursed services consistent

with such orders, POCs, and [~~prior~~service] authorizations shall be required to submit corrective action plans (CAPs) to DMAS for approval. Once approved, such CAPs shall be implemented to resolve the cited deficiencies.

B. If the DMAS staff determines, during any review or at any other time, that the waiver individual no longer meets [the aggregated] cost-effectiveness standards or medical necessity criteria, then the DMAS staff, as appropriate, shall deny payment for such waiver individual. Such waiver individuals shall be discharged from the waiver.

C. Securing [~~prior~~ service]authorization shall not necessarily guarantee reimbursement pursuant to DMAS utilization review of waiver services.

D. DMAS shall perform annual quality assurance reviews for tech waiver enrollees. Once waiver enrollment occurs, the Level of Care Eligibility Re-determination audits (LOCERI) shall be performed [~~at~~by] DMAS. This independent electronic calculation of eligibility determination is performed and communicated to the DMAS supervisor for tech waiver. Any failure for waiver eligibility requires higher level of review by the supervisor and may include a home visit by the DMAS staff.

12VAC30-120-1770
12VAC30-120-1770. Appeals; provider and recipient.

A. Providers shall have the right to appeal actions taken by DMAS. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and DMAS regulations at 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

B. Individuals shall have the right to appeal actions taken by DMAS. Individuals' appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-120-370. DMAS shall provide the opportunity for a fair hearing, consistent with 42 CFR Part 431, Subpart E.

C. The individual shall be advised in writing of such denial and of his right to appeal consistent with DMAS client appeals regulations 12VAC30-110-70 through 12VAC30-110-80.

12VAC30-120-9998
FORMS (12VAC30-120)

Virginia Uniform Assessment Instrument (UAI) (1994).

Consent to Exchange Information, DMAS-20 (rev. 4/03).

Provider Aide/LPN Record Personal/Respite Care, DMAS-90 (rev. 12/02).

LPN Skilled Respite Record, DMAS-90A (eff. 7/05).

Personal Assistant/Companion Timesheet, DMAS-91 (rev. 8/03).

Questionnaire to Assess an Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum (eff. 8/00).

Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 10/06).

Screening Team Plan of Care for Medicaid-Funded Long Term Care, DMAS-97 (rev. 12/02).

Provider Agency Plan of Care, DMAS-97A (rev. 9/02).

Consumer Directed Services Plan of Care, DMAS-97B (rev. 1/98).

Community-Based Care Recipient Assessment Report, DMAS-99 (rev. 4/03).

Consumer-Directed Personal Attendant Services Recipient Assessment Report, DMAS-99B (rev. 8/03).

MI/MR Level I Supplement for EDCD Waiver Applicants, DMAS-101A (rev. 10/04).

Assessment of Active Treatment Needs for Individuals with MI, MR, or RC Who Request Services under the Elder or Disabled with Consumer-Direction Waivers, DMAS-101B (rev. 10/04).

~~AIDS Waiver Evaluation Form for Enteral Nutrition~~ Provider RN Initial Home Assessment, DMAS-116 (~~6/03~~ 11/2010).

~~Medicaid Long Term Care Communication Form, DMAS-225 (3/09).~~

Medicaid Long Term Care Communication Form, DMAS-225 (rev. 10/11).

Technology Assisted Waiver/EPSDT Nursing Services Provider Skills Checklist for Individuals Caring for Tracheostomized and/or Ventilator Assisted Children and Adults, DMAS-259.

Home Health Certification and Plan of Care, CMS-485 (rev. 2/94).

IFDDS Waiver Level of Care Eligibility Form (eff. 5/07).

Technology Assisted Waiver Adult Aide Plan of Care, DMAS 97 T (rev. 6/08).

Technology Assisted Waiver Supervisory Monthly Summary, DMAS 103 (rev. 4/08).

Technology Assisted Waiver Adult Referral, DMAS 108 (rev. 3/10).

Technology Assisted Waiver Pediatric Referral, DMAS 109 (rev. 3/10).

Medicaid Long Term Care Communication Form, DMAS-225 (rev. 10/11).

12VAC30-120-9999
DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-120)

User's Guide: Mental Retardation: Definition, Classification and Systems of Supports, 10th Edition, 2002, American Association on Intellectual and Developmental Disabilities.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DMS-IV-TR), 2000, American Psychiatric Association.

Underwriter's Laboratories Safety Standard 1635, Standard for Digital Alarm Communicator System Units, Third Edition, January 31, 1996, with revisions through August 15, 2005.

Underwriter's Laboratories Safety Standard 1637, Standard for Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006.

PDN Authorization.

Medical Assistance Program Participation Agreement.