Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30 -120-70 through 30-120-120 REPEALED 12 VAC 30-120-1700 et. seq.
Regulation title	Waivered Services
Action title	Technology Assisted Waiver Update
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

The Department of Medical Assistance Services is repealing the existing Technology Assisted Waiver regulations (12 VAC 30-120-70 through 12 VAC 30-120-120) and promulgating new regulations (at 12VAC 30-120-1700 *et seq*.) in response to changes in the affected industry and to achieve greater consistency and clarity in content and format with the other DMAS' waiver programs. These waiver program regulations have not been substantially revised since 2000.

The following changes are addressed in this final stage action: i) definitions have been expanded and modified to provide for person centered planning, to incorporate the new acronym for Intermediate Care Facilities for Intellectually Disabled, and to incorporate the agency's new terminology for service authorization; ii) waiver participant eligibility requirements are being updated for clarification of institutional deeming rules and for consistency and clarity in the use of a Uniform Assessment Instrument for eligibility determination; iii) provider participation standards and staff qualifications are being updated consistent with current industry standards; iv) clarification of DMAS direct oversight for this waiver and authorization of services; v) update and clarifica-

tion of all waiver services and provider service delivery standards to the current industry standards; vi) clarification that assistive technology that is available through the State Plan for Medical Assistance will not be covered through the waiver; vii) inclusion and expansion on waiver participant rights and responsibilities, and; viii) update to current industry practices for the waiver individuals' right to file grievances, participate in the planning and scheduling of their own care, and exercise their appeal rights.

In response to comments received during the comment period, the changes being made in the final stage are: (i) the making up of authorized private duty nursing care within the same week is permitted; (ii) 21 days of absence from the Commonwealth is permitted; (iii) provisions that the primary caregiver has the right to participate in scheduling providers and services, and; (iv) repairs to environmental modifications which DMAS has already reimbursed are shown as covered.

DMAS was also directed, by the 2013 General Assembly, to modify the unit of service for skilled private duty nursing (*2013 Acts of the Assembly*, Item 307 QQQQ) from the current one hour to one-quarter of an hour. This change has also been incorporated into this final stage.

Other requested changes (such as covering private duty nursing for 20 hours a day) cannot be made. To do so would result in individuals' costs of care exceeding, in the aggregate, the comparable costs of institutional care in violation of federal law. The Commonwealth's receipt of federal funds is contingent upon the waiver's aggregate costs being less than the costs of comparable institutional care. Other changes are technical and editorial in nature and are made to improve clarity and readability.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency or board taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended regulations entitled Waiver Services: Technology Assisted Waiver Update (12 VAC 30-120-1700 et seq.), Repealing 12 VAC 30-120-70 through 12 VAC 30-120-120 and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the *Code of Virginia* § 2.2-4012, of the Administrative Process Act.

Date

Cynthia B. Jones, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

DMAS' Technology Assisted Waiver operates under the authority of §1915 (c) of the *Social Security Act* and 42 CFR §§ 435.211, 435.17, and 435.230 which permit the waiver of certain State Plan requirements (such as comparability of services and sufficiency of the amount, duration, and scope of services). These cited federal statutory and regulatory provisions permit the establishment of Medicaid waivers to afford the states greater flexibility to devise different approaches, as alternatives to institutionalization, in the provision of long term care services. This waiver authority permits DMAS to target specific services to eligible individuals on the basis of their diagnoses.

This particular waiver provides Medicaid individuals, who require complex medical care and substantial and ongoing skilled nursing care, with numerous supportive services thereby enabling them to remain in their homes and communities at lower costs, as opposed to being institutionalized in nursing facilities or long stay hospitals. Pursuant to federal statute, the costs of these services in the community are prohibited from costing, in the aggregate, more than the comparable institutional costs. DMAS has determined that the maximum number of private duty nursing hours that can be authorized, and remain within this aggregate limit, is 16 hours in a 24-hour period.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons it is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The waiver originally became effective in 1988 primarily for ventilator-dependant children and was approved by CMS and funded by the General Assembly. In 1997, CMS approved the addition of adults to this waiver. The impetus for the inclusion of adults derived largely from the fact that children, who had been cared for for years through this waiver, were aging out of the waiver services and had no alternative other than institutional care for their required medical care.

Advances in pediatric medicine are enabling the long term survival of severely compromised children who, just 20 years ago, would not have survived very long after birth. These regulatory changes are needed to ensure that the ongoing changes in medical technology and industry practices continue to support the health, safety, and welfare of this waiver's fragile population. DMAS anticipates that these modifications and updates will allow for provider agencies and their staff and the waiver individuals, while complying with applicable federal requirements, to continue to participate in this important and vital waiver program.

The Technology Assisted Waiver is responsible for and provides direct care coordination currently for 313 individuals who require complicated healthcare because they are chronically ill or severely impaired and dependent on sophisticated technology to sustain their lives. This population includes 219 (70%) children and 94 (30%) adults. Of the pediatric population, 137 (63%) require a tracheostomy to sustain life and 50 of them (36%) are also ventilator dependant. Of the adult population, 79 (84%) require a ventilator to sustain life. Some of the common diagnoses found for this waiver population are Amyotrophic Lateral Sclerosis (ALS), Respiratory Failure, and Cerebral Palsy.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The state regulations that are affected by this action are the Technology Assisted Waiver regulations located at 12 VAC30-120-70 through 12 VAC30-120-120 which are being repealed. New regulations are being promulgated at 12 VAC 30-120-1700 et seq.

All of DMAS waiver programs contained different definitions for the same/similar terms which caused unnecessary confusion among providers, especially for those providers who participated in more than one waiver. The existing Technology Assisted Waiver regulations contained limited requirements for individual screenings and individual eligibility requirements in regard to pre-admission screenings. There was a lack of clear criteria for alternate institutional placement as related to the age of the individual seeking consideration for waiver enrollment.

The existing regulations contained the general requirements for providers of waiver services but did not include personal care aide qualifications; training or mandated provider oversight (i.e.: providers' responsibility for documentation and record maintenance); provision for criminal record and sex offender registry checks; restrictions from hiring persons convicted of barrier crimes, and; the assurance of dignity and quality of life for waiver individuals.

The current regulations did not include waiver individual's rights and responsibilities, a statement of participants' choice of providers of services or protection from abuse, neglect, exploitation or misappropriation of property. The current regulations also did not include current standards of practice for the plan of care and skilled private duty nursing services.

These regulations required the use of the DMAS-225 (previously DMAS 122) form by the local departments of social services to communicate to long term care providers relevant information about individuals' eligibility. This form contained patient pay information that was relevant to providers' billing activities. Providers reported problems with obtaining this form in a timely manner to support their billing activities.

In addition to proposing a new uniform format (across all waiver programs) for these regulations, changes were proposed for public comment as follows: (i) definitions were updated to include current industry standards; (ii) preadmission screenings were updated to require the use of the same assessment tool (the Uniform Assessment Instrument) for all individuals seeking waiver services regardless of age; (iii) age specific assessment tools were incorporated into the revised regulations and serve as a guideline for determination of the number of skilled private duty nursing hours which can be authorized for waiver individuals; (iv) specialized care criteria are updated for final determination of waiver criteria; (v) clarification was provided for congregate private duty nursing; (vi) clarification was provided for the limitation of no more than 16 hours of skilled private duty nursing services in a 24-hour period of time and the make-up of missed nursing shifts; (vii) the inclusion of transition services under Money Follows the Person (MFP) was provided; (viii) nursing supervisory assessment visits were clarified; (ix) the plan of care was expanded to include required information elements, signatures, and timeframes; (x) annual eligibility re-determination and quality management reviews were provided; (xi) individuals' rights and responsibilities were included; (xii) protection of individuals from abuse, neglect, exploitation, or misappropriation of property was included; (xiii) providers' responsibilities for documentation and record maintenance; (xiv) provision was made for criminal record and sex offender checks; (xv) limitations were provided on providers' hiring of persons who have been convicted of barrier crimes; (xvi) the assurance of dignity and quality of life for waiver individuals was included, and; (xvii) update for the appeal for denial of coverage for waiver individuals was added.

Providers are now able to access the electronic Automated Response System (ARS) and Medi-Call to obtain information about waiver individuals' eligibility periods, patient pay responsibilities, and whether they have full or limited Medicaid coverage. Providers no longer have to wait for hard copy documents to arrive in the mail in order to complete their billing submissions to DMAS.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If there are no disadvantages to the public or the Commonwealth, please indicate.

As discussed above (see *Legal Basis*), DMAS must ensure that individuals' costs of care do not exceed the costs of institutional care in the aggregate for this waiver. To do so would result in federal disapproval of this important waiver and the loss of the related federal funds. DMAS expended, for State Fiscal Years 2010, 2011, and 2012, respectively $32,219,297; $32,506,730; $32,652,309. Half of each expenditure was federal funds so the Commonwealth's loss of such amounts would impair the ability of the Commonwealth to care for these medically fragile individuals.

In 2005 and 2006, providers approached DMAS with multiple issues involving participating in this waiver: (i) variations in the definition of terms and regulatory requirements complicated their participation in multiple waivers; (ii) certain regulatory requirements made it difficult for providers to hire adequate staff for waiver individuals' needs, and; (iii) required forms were not being secured promptly enough to support their monthly billing activities. DMAS worked with these affected entities to arrive at solutions agreeable to these parties.

The advantages to waiver individuals of these changes are the provision of assistance with transitioning out of skilled nursing facilities or long stay hospitals into community care arrangements. The advantage to providers will be the update of program requirements to conform to current industry standards. These regulations are also being formatted consistently with other waiver programs to assist providers who participate in more than one waiver.

The advantage to the agency will be the clarification of provider requirements which are expected to reduce exceptions encountered during provider reviews. Such exceptions can result in DMAS recovering expenditures which for small providers can represent substantial sums of monies to be returned to the program. These recoveries also often result in lengthy and administratively costly provider appeal actions. The reduction of recoveries and appeal actions benefits both these affected providers and the Commonwealth.

DMAS is aware of some providers' difficulties in employing sufficient qualified nursing staff to meet all of these waiver individuals' needs. Inspite of DMAS' efforts to update these regulations for providers' and families' benefit, provider agencies and families may still encounter problems with hiring and staffing the needed care hours. However, it is outside DMAS' statutory authority to resolve this issue.

Improved efficiencies in this waiver program will reduce administrative expenditures which is more cost effective for the citizens of the Commonwealth. There are no disadvantages to citizens or the Commonwealth in these proposed changes.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

Editorial changes have been made throughout the regulations to update the previously-named Intermediate Care Facility for the Mentally Retarded (ICF/MR) to the currently-used Intermediate Care Facility for the Intellectually Disabled (ICF/ID).

Section number	Requirement at proposed stage	What has changed	Rationale for change
1700	Definition of congregate private duty respite care stated that 240 hours of care was covered per calendar year per household. Definition referred to prior authorization in conjunction with service authorization.	Total hours of respite care covered changed to 360. DMAS has changed its terminology to service authorization (from prior authorization (PA)).	At time of drafting the proposed regulations, a budget bill proposal provided for 240 hours of respite care. The General Assembly funded this service at 360 hours. References to PA have been removed for consistency with operations.
1705 E	Provision limited coverage of waiver services to 14 days per calendar year for travel outside the Commonwealth.	The 14 days has been changed to 21 with the stipulation that private duty nursing hours cannot exceed the amount that has been authorized.	Response to public comment.
1710 A (9)	Provision requires primary caregiver to be responsible for a minimum of 8 hours of the individual's care in a 24 hour period as well as any hours not provided by a nurse.	Any was changed to all as this was DMAS' intent.	Response to public comment.
1710 C (6)	Provision sets out the rights of the individual's family in this waiver.	The legally competent waiver individual or parent/legal guardian has the right to participate in the care planning, scheduling of services and selection of providers and services.	Response to public comment.
1720 A (5)	Provision sets out the entity responsible for performing prior authorization of services.	DMAS has changed its terminology for prior authorization to service authorization. Authorization for skilled private duty respite services has been delegated to the agency's service authorization contractor.	Administrative procedure change made by DMAS.
1720 B	Services covered in this waiver are listed.	Personal care for adults-only is added to the list.	Response to public comment.
1720 B (1)	Skilled private duty nursing service	Qualifying language added to c(3) that the authorized PDN hours are based on the individuals' technology and nursing scores.	Language clarification for consistency with other requirements.
		Change to c(5) permits making up of missed hours within the week.	Response to public comment.
		A unit of skilled private duty nursing is changing from one hour to 15 minutes.	2013 legislative mandate.
1720 B 4	Reference to 12 VAC 30-120-758.	Reference removed.	Clarity and improved readability.
	Repairs of environmental	Text added.	Response to public com-

	modifications.		ment.
	EM exclusions.	Limits on environmental modifications clarified.	Clarity and improved readability. Declined the public comment on this issue.
1730 A 22	Record retention requirements for providers.	Waiver defines a child as up through 21 years of age.	Consistency with program policy.
1730 A 27	Providers must obtain 2 references for prospective employees.	A prospective employee who has worked as a personal care aide and for only one employer is permitted to provide 2 personal references. Prospective employer must demonstrate good faith effort to obtain professional job references for new employees.	Response to public comment.
1730 B	Provider requirements applicable to specific services.	The respite service covered in this waiver is always private duty nursing respite.	Language clarification.

Editorial corrections are being made, where a requirement is mandatory, from the use of the term 'must' to 'shall' consistent with the Registrar's Style Manual.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.

DMAS' proposed regulations were published in the November 19, 2012, *Virginia Register* (VR 29:6) for their comment period from November 19, 2012, through January 18, 2013. Comments were received from representatives of AmeriCare Plus Personal Care Agency, and 45 individuals via the public comment forum on the Town Hall.

A summary of the comments received follows:

Commenter	**Comment**	**Agency Response**
AmeriCare Plus Personal Care Agency	1. Remove the requirement that prospective employers obtain a professional reference for a nurse aide applicant who has worked for only one employer. Previous employers are reluctant to provide any references and the requirement further restricts an already limited pool of prospective nurse aides. Securing the personal reference should remain.	Prospective employers are still being required to attempt to gather at least one professional reference for nurse aides. They will be permitted to document their good faith efforts to secure professional references for the purpose of audits.
	2. Remove the requirement that nurse aides 'physically attend' 12 hours of in-service education annually. Providers should be permitted to use printed mate-	This requirement is not included in these regulations.

	rial and other media as well as having the RN supervisor provide direct instruction in the home specific to each Medicaid individual.	
	3. Remove requirement that signature times/dates be completed in the record no later than 7 calendar days from the last date of service. This standard is difficult to comply with and in some cases impossible if the Medicaid individual is hospitalized or travels unexpectedly for long periods. The absence of these signatures prevents providers from billing for appropriately rendered services.	In addition to other documentation, signatures, dates and times are required in order to verify that services were provided as billed. DMAS declines to make this change. If the Medicaid individual's departure is believed to be imminent, providers can secure more frequent verification signatures, even on a daily basis.
40 Individuals	1. Making up or trading any missed private duty nursing (PDN) shifts, days or hours within 72-hours of the missed schedule, but not to exceed 16 hours in a 24-hour period, was raised as a concern. The commenters stated that PDN missed shifts place additional hardships on parents/caregivers who can have their own jobs to get to.	The making up of any missed authorized private duty nursing hours is being permitted within the same week (Sunday through Saturday). The total hours made up may not exceed 16 hours per day for any reason.
	2. Restrictions on the daily allotment of hours were also raised as a concern. Giving families the flexibility to use their PDN hours in a weekly allotment rather than a daily allotment would significantly benefit families. During the week, there can be doctor's appointments, school activities and other responsibilities which can drive the need for more PDN hours. Weekends typically do not involve as many additional activities. Families still would not exceed their total weekly allotment of 112 PDN hours but would greatly benefit from the greater flexibility.	DMAS is accommodating this change within the constraint of no more than 16 hours of private duty nursing per day will be covered. Families are permitted to use their respite benefit for additional daily hours (up to the annual limit of 360 hours) for the relief of the primary caregiver.
	3. One of these individuals expressed concern that the agency's regulations were developed without input from families who have children served by this waiver.	DMAS worked with affected providers and a representative group to formulate the proposed stage regulations.
Individual	Flexibility of how nursing hours are used should be permitted for families who are attending to multiple, sometimes competing, responsibilities.	DMAS is accommodating this change.
Individual	The proposed language for nursing hours is very stringent and places unnecessary hardships on families. It allows for only 16 hours per day (rather than weekly allotments) and does not permit families to make up lost hours when the scheduled nurse does not work the shift. This commenter also supported the idea of allow-	DMAS is accommodating this change and no more than 16 hours of private duty nursing per day will be covered.

	ing PDN shifts to be allocated on a weekly basis rather than daily.	
Individual	1. All persons covered by this waiver should be informed about these proposed rules and the comment period should be extended for another 30 days.	DMAS has observed all of the public comment requirements set out in the *Code of Virginia* § 2.2-4000 et seq.
	2. The respite program should be more accountable to and for the individual and the hours should be increased (from 240) to 480 hours as in other waiver programs.	The 240 hours of private duty nursing respite care was a budget bill proposal that was never implemented. The General Assembly funded this benefit at 360 hours per year.
	3. The regulations need to provide for making up of missed hours of skilled PDN.	This change has been incorporated.
	4. There should be a combined maximum of skilled PDN and personal care of 20 hours per day.	Only adults are permitted to receive personal care in this waiver. DMAS covers up to a maximum of 16 hours a day of PDN-only or combined PDN and PC services.
	5. The assistive technology definition should be equipment to meet specialized medical needs, perform ADLs and/or improve their function. It should not be defined as specialized medical equipment.	The agency declines this comment as to do so would result in a unique definition for a term common to multiple waivers. The use of 'specialized medical' does not mean that requests for communication devices would automatically be denied coverage when they are found to be medically necessary.
	6. Change ADLs to ADLs/IADLs in several places.	This change has been incorporated.
	7. 12 VAC 30-120-1705 E: Change 14 days of absences from the Commonwealth to 21 days per calendar year for vacations.	This change has been incorporated.
	8. 12 VAC 30-120-1710 A(9): Change wording of second sentence to provide that the primary caregiver is responsible for all hours not provided by RNs/LPNs.	This change has been incorporated.
	9. 12 VAC 30-120-1710 C(6): Provide that the primary caregiver has the right to participate in scheduling providers and services.	This change has been incorporated.
	10. 12 VAC 30-120-1710 C(6) add: 'Be provided a monthly report of daily hours and services …….. by the 15th of the following month'.	Such requested information would be provided by the provider agency or agencies.
	11. 12 VAC 30-120-1720 B: add personal care services for adults as a covered service.	This change has been incorporated.
	12. 12 VAC 30-120-1720 B(1)(c) add to the end: 'and where 16 scheduled PDN hours are not completed within a 24 hour	This change has been incorporated.

	period, the hours may be re-scheduled and worked within the following 72 hours to support the primary caregiver'.	
	13. 12 VAC 30-120-1720 B(1)(c)(8) change 'i.e.' to 'e.g.'	This change has been incorporated.
	14. 12 VAC 30-120-1720 B(1)(d) add to the end: 'or should be out of the Commonwealth for more than 48 hours' and change the number of covered respite hours from 240 to 480 (several locations).	The first change has been incorporated. DMAS covers 360 hours of respite services per individual annually in this waiver. This change has been made throughout these regulations.
	15. 12 VAC 30-120-1720 B(3)(a): Remove 'specialized medical' from first sentence. Add IADLs to ADLs.	DMAS declines the first comment and has incorporated the second.
	16. 12 VAC 30-120-1720 B(4)(a): add 'and/or safety' to the end.	This change is declined.
	17. 12 VAC 30-120-1720 B(4)(i): Add to the end: 'Repairs of modifications are eligible.'	This change has been incorporated.
	18. 12 VAC 30-120-1720 B(4)(k)(1) should be deleted because there may be times when duplicate EM services could be warranted.	DMAS appreciates this comment but elects to retain the prohibition of duplication of EM services within the same residence and the same room of the residence.
	19. 12 VAC 30-120-1720 B (5)(d)(2): Change 16 to 20 and add the following: 'and where 20 scheduled PDN and PC 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'.	The maximum number of hours that DMAS will reimburse (whether PDN only or a combination of PDN and PC) is 16. This change concerning the rescheduling of missed shifts has been incorporated.
	20. 12 VAC 30-120-1750 B(1) and (2): Delete or update last sentence as it only pertains to 2011. Add 'as covered below' to (2).	DMAS appreciates the comment but elects to retain the connection between receiving private duty nursing and assistive technology and environmental modifications.
Physician	Suggested that the PDN hours be regulated by the week instead of daily.	This change has been incorporated.
Individual	Consider allotting the covered 16 hours of PDN on a weekly basis instead of a daily basis.	This change has been incorporated.
Individual	Consider removing the requirement that nurses must have 6 months experience working with ventilator cases. Home health agencies have difficulty finding nurses with 6 months experience working with ventilator cases. There also needs to be provision for emergency nursing care when parents/caregivers encounter their own emergencies, such as surgery recuperation, when more than 240 hours provided by the respite benefit are required.	DMAS recognizes the problems that some health care agencies may have in meeting this standard with their new employees. However, due to the fragile nature of the health of the individuals served by this waiver, DMAS believes that it could seriously endanger the health and safety of the waiver individuals to permit agencies to hire staff who lack a minimum of 6 months ventilator case experience. DMAS covers 360 hours of respite services for

		this waiver.

All changes made in this regulatory action

Please list all changes that are being proposed and the consequences of the proposed changes. Describe new provisions and/or all changes to existing sections.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
12VAC30-120-70 th 120		Sets out all of the regulatory requirements for the Technology Assisted Waiver.	Old waiver regulations are being repealed as part of the agency's action to bring more consistency and uniformity to its multiple waiver programs. The same waiver regulatory format is being adopted across all waiver programs.
12VAC30-120-1700	Definitions.	Sets out all of the regulatory definitions for the Technology Assisted Waiver.	Old definitions are being expanded to allow for updates which include current industry standards, standards of practice and laws.
12VAC30-120-1705	Waiver description and legal authority	New provision over previous old regulations.	Sets out the federal statutory authority for this waiver as well as federal limitations.
12VAC30-120-1710	Individual eligibility requirements; Preadmission screening	Comparable to the parallel existing 12VAC30-120-80 B and C	Sets out the federal statutory cite for this waiver as well as use of the same assessment tools (the Uniform Assessment Instrument) for all individuals seeking waiver services regardless of age and includes all updates for specialized care criteria. Establishes consistency across all waivers for preadmission screening requirements. Annual eligibility-re-determination and waiver individual's rights and responsibilities are updated.
12VAC30-120-1720	Covered services; limits; changes to or termination of services	Comparable to the parallel existing 12VAC30-120-90 A, B and C	Sets out the federal statutory cite for this waiver as well as the clarification of the federal limitations in regards to waiver services, skilled private duty nursing hours and termination from the waiver itself. Reductions in several

			specific services (covered respite hours, AT and EM) are resulting from the 2010 Appropriations Act are also proposed.
12VAC30-20-1730	General requirements for participating providers.	Comparable to the parallel existing 12VAC30-120-100	Sets out the general requirements for providers including checking for the commission of barrier crimes and mandated criminal record checks. Inclusion of mandated reporting for suspected abuse, neglect, exploitation or misappropriation of property. Inclusion of standard freedom of choice provisions, requirement to use person-centered planning, guarantee of provision of civil rights, etc. The federally mandated checks of persons and entities appearing on the List of Excluded Individuals and Entities has been added.
12VAC30-120-1740	Participation standards for provision of services.	Comparable to the parallel existing 12VAC30-120-110 A,B and C	Clarifies all required assessments and the development of the Plan of Care.
12VAC30-120-1750	Payment for services.	Comparable to the parallel existing 12VAC30-120-100 A, B and D.	Sets out required limits for the payment for these services.
12VAC30-120-1760	Utilization review; level of care reviews.	Comparable to the parallel existing 12VAC30-120-15 B.	Old regulations are being updated to include Quality Management Reviews.
12VAC30-120-1780	Appeals.	Comparable to the parallel existing 12VAC30-120-120 A and B.	Update for the appeal of denied coverage rights for waiver individuals.