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_30-120-900 et seq.
Regulation title	Waiver Services
Action title	Elderly or Disabled with Consumer Direction
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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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 previous proposed stage amendments to the DMAS' home and community based Elderly or Disabled with Consumer Direction (EDCD) Waiver program provided for the following changes: (i) allowing for Licensed Practical Nurses (LPNs) to supervise, as permitted by their professional licenses, personal care aides under agency-directed personal care and respite care services; (ii) requiring personal care agencies to ensure that the personal care aide has the required skills and training to perform services as specified in the individual's Plan of Care; (iii) replacing the DMAS-122 form with the Medicaid Long-Term Care Communication Form (DMAS-225) along with the use of an automated electronic system for providers' use; (iv) removing licensing-type standards that apply to the physical plant of the adult day health care center; (v) permitting providers more time to secure service verification signatures, and; (vi) providing for person-centered planning.

Further changes will permit, based on the personal care agency's assessment of the waiver individual, (i) longer periods of time between supervising Registered Nurse/Licensed Practical Nurse (RN/LPN) supervisory visits; (ii) new standards, consistent with licensing statute and regula-

tions, are recommended for the new supervisory provider type of LPN, and; (iii) the Medicaid contracted Fiscal/Employer Agent will now be responsible for obtaining criminal record checks for personal care aides in consumer-directed services. DMAS is proposing a universal format for all of its waiver regulations to facilitate provider participation across more than one waiver. As such, some existing regulation sections are being repealed with the content being merged into new sections in support of this new format.

The changes that are being made in this final stage include: (i) outdated/inappropriate VAC and COV citations are being removed; (ii) defined terms that are not used in the body of the regulations are being removed; (iii) providers are being required to document, in the individual's record, that agency-directed care was selected by the individual; (iv) the service limit of 56 hours for agency-directed personal care services is being moved; (v) the respite service limit of 480 hours is changing from calendar year to state fiscal year in conformance with legislative mandate; (vi) the currently effective knowledge, skills, and abilities of Consumer-Directed services facilitators (see 12 VAC 30-120-980 D) are being added back to this final stage in response to public comments; (vii) the RN supervisor, employed by the personal care agency, will have to evaluate the LPN supervisor's work performance every 90 days instead of every six months; (viii) all dual references to Prior Authorization/Service Authorization are being changed to just Service Authorization (Serv Auth); (ix) special actions that were required for Medicaid individuals who have cognitive impairments are being removed; (x) prospective employers' checks of sex offender registries are being removed because it was duplicative of barrier crimes checks; (xi) parents of adult waiver individuals can be reimbursed by Medicaid for caring for their child as long as the parents meet the attendant qualifications; (xii) removal of 'good faith effort' by providers to obtain appropriate prior job references, and; (xiii) editorial changes are made for improved readability and clarity.

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 Elderly or Disabled with Consumer Direction Waiver (12 VAC 30-120-900 et seq.) 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.

5/13/2013
Date

/s/ Cynthia B. Jones
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 and 325, 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' Elderly or Disabled with Consumer Direction (EDCD) Waiver operates under the authority of § 1915 (c) of the *Social Security Act* and 42 CFR § 430.25(b)(2) which permit the waiver of certain State Plan requirements. These cited federal statutory and regulatory provisions permit the establishment of Medicaid waivers to afford the states greater flexibility to devise different approaches to the provision of long term care services. This particular waiver provides Medicaid recipients who are either elderly or who have a disability with numerous supportive services to enable such individuals to remain in their homes and communities at lower costs, as opposed to being institutionalized in nursing facilities.

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.

This regulatory action updates the EDCD Waiver to accommodate changes in the industry and to provide greater clarity in these regulations. These proposed changes do not affect the health, safety, or welfare of citizens. They are intended to remove physical plant standards that, subsequent to DMAS regulations of several years ago, have been adopted by the Virginia Department of Social Services. They also intend to simplify and clarify provider requirements by permitting reasonable variances from waiver individuals' POCs. This action also provides for the adoption of person-centered planning processes in conformance with federal guidance.

DMAS has also adopted a uniform organizational structure, consistent definitions of terms for all of its waiver programs' regulations, and consistent service requirements across all waivers in order to make it easier for providers to render services (such as skilled nursing care) in more than one program. The revised organizational structure set out in these revisions is consistent with that effort.

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 Elderly or Disabled with Consumer Direction Waiver (12 VAC 30-120-900 et seq.).

CURRENT POLICY

Currently, these regulations require the use of the DMAS-122 form by local departments of social services to communicate, to long term care providers, relevant information about waiver individuals' eligibility and patient pay amounts. With the patient pay information on the DMAS-122 form, providers are thereby are enabled to submit their claims to DMAS.

Currently, the existing adult day health care services regulations contain providers' standards, similar to licensing standards, applicable to the centers' physical plants, staffing requirements, and nutrition services. These were developed because of the absence of any licensing agency's standards. For agency-directed personal care services, DMAS requires that the nurse supervisor perform visits (for initial assessments and follow up visits) to waiver individuals' homes within specified numbers of days depending on whether the waiver individual has a cognitive impairment or not. Current regulations require that DMAS approve personal care aide training classes for agencies. Current regulations permit someone who is only 10 years old to provide personal care aide services. Current regulations set a standard of a minimum of 40-hours of training for personal care aides. Currently, the regulations require that the consumer-directed services facilitator perform criminal record checks.

ISSUES/RECOMMENDATIONS

Changes are proposed as follows: (i) to allow for LPNs to supervise, as permitted by their professional licenses, personal care aides under agency-directed personal care and respite care services; (ii) to require personal care agencies to ensure that the personal care aide has the required skills and training to perform services as specified in the waiver individual's supporting documentation; (iii) to correct the typographical error of the age of 10 years old to 18 years old for program aides in Adult Day Health Care; (iv) to reflect the replacement of the DMAS-122 form with the Medicaid Long-Term Care Communication Form (DMAS-225) along with the use of an automated electronic system for providers' use; (v) to remove licensing-type standards that apply to the physical plant of the adult day health care center; (vi) to permit providers more time to secure service verification signatures, and; (vii) to require agencies to secure criminal record checks on persons in their employ.

Further changes will permit, based on the personal care agency's assessment of the recipient, (i) longer periods of time between supervising RN and LPN supervisory visits; (ii) new standards,

consistent with licensing statute and regulations, for the new supervisory LPN provider type; (iii) agencies ensuring that its aides have the training and skills required to perform the services required in waiver individuals' POCs; (iv) the Medicaid contracted Fiscal/Employer Agent will now be responsible for obtaining criminal record checks for personal care aides in consumer-directed services, and; (vi) new service authorization limits are proposed for the existing covered services of assistive technology and environmental modifications pursuant to the authority of 42 CFR 440.230(d).

Duplicative statements, (such as in 12VAC 30-120-930(I)(4) and 12VAC30-120-970), are being removed to improve clarity and reduce confusion. DMAS is also adopting a universal format and consistent definitions, where possible, for all of its' home and community based waiver regulations to facilitate provider participation across multiple waiver programs in response to provider requests.

Some additional suggestions received from commenters during the proposed stage comment period are also addressed. No changes are recommended for the eligibility criteria to be applied to waiver applicants nor are any new services, nor increases to the covered services, are being recommended.

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.

Prior to the NOIRA comment period, representative provider organizations addressed several issues with DMAS, as follows: (i) the need for a reasonable period of time to secure waiver individuals' or family members' signatures on provider records to document service delivery, and; (ii) alternative ways for providers to determine waiver individual eligibility status and patient pay amounts. All of these provider concerns are addressed in these final stage regulations. Furthermore, DMAS has instituted an automated system for providers' use to facilitate their determination of waiver individuals' eligibility status and patient pay requirements in support of their billing processes.

A third issue, providers' need to appropriately and legitimately vary from individuals' plans of care will be addressed in the agency's guidance documents.

The advantage of incorporating these changes into the regulations for providers is that they will enhance providers' ability to successfully render services across multiple waivers as well as effecting successful conclusions of their provider audits. Such changes will be beneficial to the agency and the Commonwealth due to reduced provider payment recoveries, which have resulted from failed provider audits. Such recoveries require considerable agency administrative time and

costs and also drive provider appeals which are also administratively costly. There are no disadvantages for citizens or the Commonwealth in this action.

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.

Section number	Requirement at proposed stage	What has changed	Rationale for change
§ 900	Prior authorization and service authorization are linked together across several definitions and several regulations.	References to prior authorization are being removed.	DMAS changed its terminology for prior authorization to service authorization several years ago. Providers are accustomed to the new terminology so keeping it linked to the replaced term is no longer necessary.
§ 905 H	There were 5 reasons that an individual could be terminated from waiver participation.	A sixth reason is being added to this list.	The failure of the waiver individual to have a back-up plan of care can cause him to be removed from waiver participation as this can result in serious threat to his health, safety, and welfare. This provision occurred at 12 VAC 30-120-924 D(1)(c) in the proposed stage and is being repeated in 905 H for consistency and clarity.
§ 924	The minimum types of services that an Adult Day Healthcare provider is required to offer included transportation.	Transportation is removed from the minimum list of ADHC services.	Transportation is available through DMAS' contracted transportation broker.
	Personal care services are limited to 56 hours/week.	Proposed provision re-located to subdivision 2 which contains all the limits on personal care.	Placing the 56 hour limit under the item about work/postsecondary school was not accurate.
	Assistive Technology (AT) and Environmental Modifications (EM) were limited to maximum expenditures of $3,000 during CY 2011	The reduced maximum expenditure is replaced with the previous expenditure limit of $5,000.	Legislative action restored the expenditure limit to $5,000.
	To receive EM, individuals were required to be receiving at least one other waiv-	This restriction has been clarified.	This language is redundant. This limit was replaced by tying receipt of

	er service.		EM to participation in the Money Follows the Person program and EDCD enrollment.
§ 930 A (19)	Prospective employers must secure at least 2 references from previous employers for new employees.	Prospective employers will be able to demonstrate and document good faith efforts to obtain 2 references if they are not able to comply with requirement.	In response to public comment.
§ 930 H	Changes or terminations of services must be reported to the waiver individual and family/caregiver. Appeal rights must be afforded.	The requirement that changes or terminations of care must be reported applies to the waiver individual and not the family/caregiver. Provider appeal rights has been moved.	Federal regulations afford the right to appeal such changes to the Medicaid individual and not the family/caregiver so this change conforms the regulation more closely with federal requirements. For consistency with the new regulatory format for waiver regulations.
§ 935 F	For agency directed personal care, the RN supervisor was required to evaluate the LPN supervisor's performance every 6 months. Payments for live-in family member or caregiver supported by objective written documentation.	Six months is being changed to 90 days. Provider makes determination and documents it in waiver individual's record.	Consistency with VDH licensing requirements. Changes make this provision consistent with all DMAS waivers containing this item. Affects agency-directed personal care/ respite care services and consumer directed personal care/respite care services.
§ 935 G	For episodic respite care, the RN supervisor is required to conduct a home visit, for the purpose of evaluating the RN/LPN service provider, at the start of respite care and then again during the second respite care visit. Required contents of respite care LPN records were omitted from proposed.	The RN supervisor's supervisory visit is to occur at the start of episodic respite services and then again either every six months or when half of the approved respite care has been used, whichever comes first. LPN respite record contents are detailed.	Consistency with consumer directed model of service delivery. To support DMAS' ongoing monitoring.
§ 935 H	The Consumer Directed services facilitators for personal and respite care services were generally required to have sufficient knowledge, skills, and abili-	Specific knowledge, skills, and abilities existed in 12 VAC 30-120-980 D which is being repealed.	Existing requirements in 980 D have been copied over into 930 H in response to public comments.

	ties to perform the job. The CD services facilitator must review the respite POC either every 6 months or when half of the approved respite care has been used. Waiver individuals' responsibilities referred to personal care attendants but omitted respite care attendants.	 'Whichever comes first' is being added. Attendants in consumer directed services are permitted to provide either personal care or respite care.	 To clarify the 'or' condition and for consistency with agency-directed respite care services. The 'personal care' qualifier is being removed so that the provision applies to both personal care and respite.
§ 935 J	Assistive technology must be delivered within 1 year from the start date of service authorization.	The 1 year has been reduced to 60 days. Providers are being required to ensure the functionality of the AT.	To ensure individuals receive medically necessary technology within a reasonable time frame in response to public comment. To avoid potential issues of a piece of AT being broken or missing a part, providers are being required to ensure its operability.
§ 945 B	Receipt of AT/EM services was linked specifically to receipt of transition coordination services.	Linkage to MFP remains but is worded more generally. References to another waiver's regulations are removed.	Response to public comment. For clarity.
§ 990	Quality management reviews and level of care reviews	Reference to prior authorization (old terminology) is changing to service authorization.	Consistency with other regulations terminology.

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 October 8, 2012 Virginia Register (VR 29:3) for their comment period from October 8, 2012 until December 8, 2012. Thirty-six comments were received from: Personal Touch Home Care; Virginia Association for Home Care and Hospice; Virginia Association of Personal Care Providers; Chestnut Grove Assisted Living; Care Advantage; KePro; AmeriCare Plus, Virginia Association of Centers for Independent Living, Virginia Board for People with Disabilities, ARH, four unnamed interested parties/consumers. A summary of the comments received and the agency's responses follows:

Commenter	Summary of Comments	Agency Response

Personal Touch Home Care	The commenter requested clear language as to the approval of electronic medical records instead of just mentioning the aide record. The use of ATL for aides to call in and out from patients' home numbers and to enter his tasks.	DMAS is developing regulations on electronic medical records that will apply to all Medicaid providers. This action is still pending completion of the executive branch review.
VA Association for Home Care and Hospice	The Association was in general agreement that the revisions to these regulations are long overdue. The Association stated that it believes that the current regulations are in conflict with best practice standards and are inconsistently applied to a variety of consolidated programs.	DMAS appreciates this comment.
	1. 'Agency-directed model' of services is now required to be licensed so there should be consistency between VDH and DMAS.	DMAS refers to VDH regulations where applicable.
	2. 'Direct marketing' definition creates unfair potential for inducement for persons receiving consumer-directed services.	Direct marketing is prohibited for consumer-directed services as well as agency-directed services.
	3. Several definitions need to be revised to correct confusion, conflicts with other laws, etc.	'Employer of Record': definition has been modified. 'Level of care' this definition is unchanged. 'Medication administration': definition has been removed, as it is not used in these regulations. 'Participating providers': The revised definition will stand. 'Services facilitator' knowledge, skills and abilities requirements are being added to section 930.
	4. Sec 910 is difficult to follow	Section 910 is being re-

	and needs clarification.	pealed.
	5. Sec 924 is missing LPN respite services.	LPN respite services are included at 12VAC 30-120-924 E.
	6. Inequities between consumer directed care and agency directed care need to be addressed.	DMAS strives to ensure consistency between the agency-directed and the consumer-directed models of care where possible.
	7. Sec 930 A (19) alternative wording was suggested concerning two required references from prior employers.	DMAS is maintaining the requirement that 2 reference checks be performed.
	8. Sec 930 B should reflect the federal 'do not hire' language.	Section 930 A.1 already includes language regarding the List of Excluded Individuals and Entities (LEIE).
	9. Sec 930 I should be removed as the requirements are now a VDH licensure requirement.	Not all requirements are specified in VDH regulations. Changes have been made to refer to VDH requirements where applicable.
	10. Sec 930 A should prohibit a business' employment of persons convicted of barrier crimes.	It is outside this agency's statutory authority to prohibit businesses from hiring persons who have been convicted of barrier crimes. Section 930 prohibits Medicaid's payment for Medicaid-covered services provided by such persons as this falls within DMAS' statutory purview. Once an employee is determined to have committed barrier crimes, DMAS will not pay for the services performed by that person. Additional information will be outlined in the EDCD provider manual.
	11. 'Payment for services furnished by family members or oth-	DMAS will retain the requirement for 'objective

	er live-in caregivers living under the same roof as the waiver individual must have specific requirements established by DMAS rather than 'objective documentation'.	written documentation' when services are provided by a family member or caregiver living under the same roof as the individual. There are many circumstances and situations that could be appropriate for these persons to provide services; DMAS does not want to limit the appropriate use of live-in caregivers where they are necessary to avoid institutionalization.
	12. Sec 945 DMAS should pay for staff training hours.	This is an expense for providers who do business with DMAS. DMAS does not receive General Fund appropriations for this purpose nor are there any federal funds available for DMAS to use to reimburse providers for the costs of training their staff.
	13. Regulations should permit the use of electronic tracking, signatures and records.	DMAS is in the process of developing regulations regarding electronic medical records that will be applicable to all Medicaid providers. These regulations are still undergoing executive branch review.
	14. The consolidated regulations are hard to read and somewhat disorganized in the way they have been consolidated.	DMAS understands this comment. The regulations have been reformatted in an effort to provide standardization among HCB waiver programs for ease of providers' use across multiple waivers.
	15. 'We strongly urge that the regulations include more detailed oversight for consumer-directed care, how it is used by consumers,	The oversight for consumer-directed services is consistent with that for agency-directed services.

	who are accountable for service delivery and the level of DMAS oversight for quality'.	Services facilitators submit authorization requests which are reviewed to ensure DMAS criteria are met. DMAS or its contractor performs quality management reviews and audits of services rendered.
VA Association of Personal Care Providers	1. Remove the requirement that providers obtain a professional reference for a nurse aide applicant who has only worked for one employer. Medicaid providers have found that former employers are unresponsive to reference requests, thereby eliminating a percentage of potential applicants. This commenter requested that only personal references be required.	References from a previous employer are required to document previous job experience which supports an aide's ability to perform the work for which DMAS is billed.
	2. Remove the requirement that nurse aides physically attend 12 hours of in-service education. Providers should be allowed to use printed material and other mediums. It is sufficient to require RN supervisors to provide instruction in the home during home visits when nurse aide deficiencies are identified that are recipient-specific.	This requirement has been changed to be consistent with VDH requirements. The provider must maintain documentation that aides have annually received 12 hours of training.
	3. Remove the requirement that signatures, times, and dates be placed in the recipient's medical record no later than 7 calendar days from the last date of service. In some cases, it is impossible to comply with this standard leaving the provider without a remedy with which to submit his claim for services rendered.	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.

Chestnut Grove Assisted Living	This commenter wanted to know why assisted living is not included in a VA waiver. This commenter provided several cost and payment rate amounts. This commenter pointed out that Medicaid coverage would mean 50% federal funding.	DMAS appreciates this comment but currently has no appropriations nor federal or state authority to support the coverage of such a service.
Care Advantage (9 people)	These commenters stated that Registered Nurses (RN) who have 1 year of experience are fully capable of managing personal care clients. The commenters disagreed that personal care aides should be required to physically attend 12 hours of yearly in-service training. The commenters stated that the monthly handouts that are developed by the provider constitute adequate in-service training. The commenters pointed out that the 12 hours of yearly in-service training was a burden to aides who may be single parents having their own families to care for. The commenters stated that RNs should perform all supervisory visits rather than permitting Licensed Practical Nurses (LPNs) to also conduct supervisory visits. The commenters also stated that supervisory visits should not be reduced to only every 90 days. Disagreement was expressed concerning the supervising RN/LPN being available by phone at all times to the <u>waiver individual</u>. This creates an additional expense for providers for which DMAS does not reimburse and also an undue hardship. Emergency calls	The final stage regulations change the requirement for the RN to have 1 year of experience instead of the current 2 year requirement. The requirement for annual personal care aide training has been changed to be consistent with VDH requirements. The provider must maintain documentation that aides have annually received 12 hours of training. The change in supervisory visits requirements is consistent with VDH requirements and the LPN scope of practice. Supervisory visits must be made more often than every 90 days if needed. In 12 VAC 30-120-935 F(3)(e), DMAS proposed that the RN/LPN supervisors be available to the <u>aide</u> by telephone at all times that <u>the aide is providing services to the waiver individual</u>. DMAS

	should be handled through the '911' system and non-emergencies can be handled the next business day.	did not propose that the RN/LPN supervisor had to be available to the waiver individual. Current EDCD regulations and VDH require that an RN/LPN supervisor be available to the aide by phone at all times that the aide is caring for the individual.
KePRO	This commenter stated that provision should be made to insure providers, case managers, and coordinators realize that there are no automatic renewals of service authorizations. Providers are required to submit clinical documentation of medical necessity prior to the expiration of the service authorization to insure continuity (of services).	This information will be detailed in the provider manual.
AmeriCare Plus (9 commenters)	The commenters stated that the requirement that employers must obtain a professional reference for a nurse aide applicant should be removed. These commenters stated that providers have found that former employers are often non-responsive to reference requests. The commenters stated that the requirement for nurse aides to physically attend 12 hours annually of in-service training should be removed. The commenters also stated that the requirement that signature times/dates must be placed on the	A reference from a previous employer is required to document existing knowledge and experience to perform the tasks for which DMAS is to be billed. The requirement for annual personal care aide training has been changed to be consistent with VDH requirements. The provider must maintain documentation that aides have received 12 hours of training annually. In the previous proposed stage, DMAS increased this time period from by the end of the week of service delivery to 7 calendar days from the last date of service. There-

	patient's record no later than 7 calendar days from the last date of service should also be removed. There are many reasons why meeting this time standard cannot be realized by providers resulting in their not being able to bill Medicaid for rendered services.	fore, DMAS declines to increase this time limit further. In addition to other documentation, signatures, dates and times are required in order to verify that services were provided as billed. Providers can obtain more frequent verification signatures if the individual's departure is believed to be imminent.
Virginia Association of Centers for Independent Living	Revise definitions of Employer of Record, guardian, primary caregiver. The proposed definition for prior authorization/service authorization is required before a service is rendered or reimbursed. Several services are not authorized prior to service delivery, for example, transition coordination. Service authorization is provided after the service occurs.	'Employer of Record' definition has been modified 'Guardian' definition has changed to incorporate the citation from the *Code of Virginia* 'Preadmission screening' definition has been modified in response to this comment. 'Primary caregiver' has been changed in response. The service authorization definition states that authorizations must be obtained prior to the service being rendered *or* reimbursed. For services requiring service authorization, this is accurate.
	Sec. 905: The new requirement that prior authorization is required when services are rendered outside the Commonwealth is unnecessary as long as the services are documented as needed on the plan of care and the total number of hours does not change.	This requirement is not new; the language is currently at 12VAC 30-120-920.
	Sec. 920: (i) insert age limit applicable to PACE services for clarity; (ii) clarify that transition coordina-	(i)This change has been made; (ii) For consistency, this language has been

	tion/services can be provided to an individual in a psychiatric residential treatment facility; (iii) revise last sentence of D.1. to allow any individual to choose an Employer of Record.	changed to reference the Money Follows the Person Demonstration; (iii) This change has been made.
	Sec. 924: Add 'or other service' to the end of B.1.c.; add an item to provide for the agency documentation of the individual's choice of agency directed services.	B.1.c. Change has been made. An item has been added to require agency documentation of choice of agency-directed service model.
	Supervision should be permitted in work settings or postsecondary education settings if it is not being provided due to the ADA or Rehabilitation Act;	Supervision, as a component of personal care, is only provided when all criteria are met and is not available in work or education settings. Supervision is only covered if the waiver individual is either alone for long periods of time or if there is no other competent person in the home who can call for help in an emergency.
	Training should be provided to the EOR and not the individual/family caregiver;	DMAS concurs that training is provided to the EOR and this change has been made.
	Replace reference to Chapter 790 with Code of Virginia reference.	The reference to Chapter 790 has been changed to the *Code of Virginia* citation.
	Sec. 930: The required knowledge, skills, and abilities for services facilitators should be included; provide specific citation to VDH TB screening requirements.	The existing knowledge, skills, and abilities requirements for services facilitators (currently in 12 VAC 30-120-980 D) have been added to section 930 as a result of public comment. The

		needed information about the VDH's TB requirements is located on that agency's website.
	Sec. 935: Personal care services should not require the family/caregiver and services facilitator to meet face-to-face;	Face-to-face meeting requirements have been clarified.
	Describe 'special tasks' that could be performed by an attendant;	Additional information regarding “special tasks” will be included in the policy manual.
	Results of record checks by local DSS should be reported to the EOR;	Reporting of record check results to the EOR has been clarified.
	Plan of care goals, objectives, and activities should be removed from regulations as these are not part of EDCD waiver services facilitation;	The requirement for review of the plan of care goals, objectives, and activities has been removed.
	Modify fourth sentence for an individual to select an EOR of choice.	The change has been made to allow an individual to select an EOR.
	Sec. 945: last sentence should be modified to provide that someone who changes to another waiver that provides Assisted Technology will have access to the new waiver's AT benefit.	DMAS declines to make this change. The language as written allows for an individual to access AT up to the maximum allowable under the Waiver. DMAS does not have sufficient appropriations in order to provide Medicaid individuals with double AT benefits. The policy manual will provide additional clarification.
Virginia Board for People with Disabilities	The Board stated its concurrence with and repeated the same comments submitted by VACIL.	DMAS appreciates the collaborative efforts of the various interested entities.
ARH (2 people)		

	The commenters stated that the requirement that employers must obtain a professional reference for a nurse aide applicant should be removed. These commenters stated that providers have found that former employers are often non-responsive to reference requests. These commenters stated that the requirement for nurse aides to physically attend 12 hours annually of in-service training should be removed. The commenters also stated that the requirement that signature times/dates must be placed on the patient's record no later than 7 calendar days from the last date of service should also be removed. There are many reasons why meeting this time standard cannot be realized by providers resulting in their not being able to bill Medicaid for rendered services.	A reference from a previous employer is required to document existing knowledge and experience to perform the tasks for which DMAS is to be billed. The requirement for annual personal care aide training has been changed to be consistent with VDH requirements. The provider must maintain documentation that aides have received 12 hours of training annually. DMAS declines to make this change. Providers can secure more frequent verification signatures if the individual's departure is expected to be imminent.
Interested Party	The barrier crime statutes are different from those currently used; EOR definition should be expanded to reflect current practice; EOR reference should stand alone when speaking of EOR responsibilities; MFP definition should be expanded beyond transition services; Services facilitators (SF) and pro-	Unnecessary references to barrier crime sections have been deleted. The EOR definition has been modified. The regulations have been changed for the term EOR to stand alone. The MFP definition is constrained by the federal waiver requirements but has been modified for clarity.

	viders are referenced separately; since SFs are providers there is no need for the separate reference.	DMAS concurs that services facilitators are providers and the regulations have been changed to use the term "providers" to be inclusive of services facilitators.
	Sec. 924: Clarify that individuals who cannot assure health, safety, welfare or back up plan are not eligible for EDCD waiver;	This has been clarified in the regulations.
	Clarify 'timesheet discrepancies';	Clarification of 'timesheet discrepancies' will be provided in the policy manual.
	"current practice reflects 480 hours per FY but that does not reflect current practice of 480 per CY";	The respite limit is per state fiscal year, the regulations have been changed to reflect this.
	Why does the EOR have to maintain copies of attendant timesheets for SF review when the FEA makes all timesheets available through their portal?;	The requirement for the EOR to maintain timesheets has been removed as a result of this comment.
	Statement at F.2.a.4 is not clear;	DMAS could not locate such reference in these regulations. Commenter did not provide contact information so DMAS could seek clarification.
	Transition services—institutions should be broadened to incorporate all qualified institutions.	Transition services and institutions is constrained by the federal waiver. The language related to transition services has been clarified related to qualifying institutions.
Anonymous	Sec. 930: Criminal record check results should not be retained in an employee's file but proof of the check should be retained;	Retention requirements for criminal record check documentation have been clarified.

	Personal care agencies are all now licensed by VDH so is this section needed?;	Not all personal care agencies are licensed by VDH and not all requirements are specified in VDH regulations. Changes have been made to refer to VDH requirements where applicable.
	What if the personal care aide does not have a Social Security Number but has a work visa?	All individuals working legally in the U.S. are required to have a valid Social Security Number.
	Clarify the barrier crimes COV and if the person has to be free of convictions from both lists.	Unnecessary barrier crime sections have been deleted.
	What are the VDH criteria for TB screening?	The VDH criteria for TB screening will be detailed in the provider manual.
	Revise the SF qualifications to be consistent with current requirements except permit a minimum of an associates' degree in a health or human services field or 2 years of satisfactory work experience in a human service field working with individuals who are elderly or disabled.	Services facilitator requirements have been included in section 930. DMAS is currently reviewing minimum requirements for services facilitators so no changes will be made at this time to existing criteria pending completion of this process.
	Approved hours cannot be exceeded.	It is correct that approved hours cannot be exceeded.
Interested Party	Definition: Remove the clause about supervision from the PERS definition.	Change has been made.
	Sec. 920 C: Change to a maximum of 5 hours/day of personal care for individuals in ALF. Rarely does someone living in the community	Change has been made.

	need 5 hours/day of ADLs so why permit in AL?	
	Sec. 925 B & D: (i) Change POC to reflect current practice; (ii) remove transportation;	(i) Change has been made in § 924 B1b. (ii) Change has been made.
	(iii) what about services in other school years besides postsecondary school?	(iii) EDCD services cannot be provided for payment by Medicaid if they are the responsibility of another entity such as a school system. Schools are required to meet the Waiver-enrolled child's personal care needs through the schools' resources.
	Clarify that the 56 hour week limit applies to consumer-directed personal care as well as to agency-directed and needs to be moved;	The language regarding the 56 hr per week limit for personal care has been moved to a more appropriate location.
	Change CY to FY.	The respite limit is per state fiscal year, the regulations have been changed to reflect this.
	Add 'or attendant'; remove clause about supervision (Ic(1));	Changes have been made.
	add NF;	Instead of adding NF, DMAS has added a reference to CMS citation for MFP.
	Add that the assessment for AT services cannot be done by provider of AT services as is current practice.	The language prohibiting AT assessments from being performed by the provider of the AT is included in the regulations.
	Sec. 935: Add ongoing supervisory visit requirements for episodic	Changes have been made to be consistent with the

	respite; add a supervisory visit after 240 hours have been used; change to 'other' records; a year is too long for an individual to wait for AT—change to 30 days.	requirements for consumer-directed respite. Change has been made to require the delivery of AT within 60 days of the start date of the service authorization.
Consumer	Finding personal care aides in rural VA is a challenge; low pay rates, travel time and gas money make this field unattractive. Requiring 12 hours of physically attending formal training is too stringent and may be a deterrent. PCAs can learn via printed matter, videos, on the job.	The requirement for annual personal care aide training has been changed to be consistent with VDH requirements.
Jill's House	This commenter is requesting that EDCD waiver have parity with other waivers and include transportation to and from Medicaid-approved provider. Concurs with the 'longer periods of time' between the RN/LPN supervisory visits.	Transportation issue resolved. DMAS appreciates the support regarding supervisory visit time frames.
Interested Party	Is EDCD reverting to calendar year for respite? Is DMAS looking to ramp up the requirements on service coordination persons or is this the current vision?	Respite will remain state fiscal year. The Department will be drafting language to strengthen the requirements for services facilitators, as required by 2012 budget language.

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.

New regulation sections are being created to conform these existing regulations to the uniform regulatory format for waiver services. This new format has been devised for the purpose of consistency across all waiver programs and for ease of use by providers who operate in multiple waivers.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
§ 900		Definitions.	Definitions have been expanded and modified as needed: (i) to protect waiver individuals' health, safety, and welfare; (ii) to conform to licensing standards; (iii) to better define covered services; (iv) to eliminate terms that are no longer used in the regulations; (v) to add medical professionals who are authorized to render services in this waiver; (vi) to distinguish between hands-on caregivers in the agency-directed and consumer-directed models of care; (vii) to update form numbers/names, affected state agency names, and generic terminology.
	§ 905	New section.	Contains waiver description and legal authority and addresses several over-arching limits for waiver individuals that either are not in current regulations or are stated in provider manuals and other guidance documents.
§ 910		Existing section being repealed.	General coverage statements have been moved to new waiver sections or deleted because of redundancy.
§ 920		Existing section being modified.	The word 'recipient' being changed to 'individual' to conform to person-centered planning terminology. Duplicate text removed. Service limits for waiver individuals who reside in assisted living facilities are clarified. Waiver individuals' responsibilities when they select consumer-directed services are clarified.
	§ 924	New section.	Merges service limit requirements of existing §§ 940, 950, 960, 970, and 980 which are being repealed. Also provides for voluntary and involuntary dis-enrollment from consumer-directed model of services and waiver individual choice in changing to the agency-directed model of care.
§ 925		Existing section.	Provides for EDCD waiver individuals who also have a diagnosis of intellectual disabilities to receive respite services in children's residential facilities that are licensed.
§ 930		Existing section being modified.	Adding the federally required List of Excluded Individuals or Entities (LEIE) requirements for providers. Clarifies provider requirements for confidential handling of waiver individuals' records and files. Adds provider requirements to conduct searches of criminal records when hiring new personnel. Adds requirement of contract termination in cases of either felony convic-

			tions or having pled guilty to felony charges. Adds staff education and training requirements consistent with licensing standards as contained in the *Code of Virginia*. Creates training requirements for staff of personal care agencies which are not licensed by the Virginia Department of Health.
	§ 935	New section being created.	Merges service-specific provider requirements from current §§ 940, 950, 960, 970, and 980 which are being repealed. ADHC provider requirements that are now captured by VDSS licensing standards are being replaced with service standards necessary for DMAS reimbursement. A new subsection for services facilitation for consumer-directed services is provided to clarify DMAS' reimbursement requirements. Coverage of AT and EM services only in conjunction with MFP (the transitioning of individuals from facilities to the community) is continued as in the current regulations.
§ 940		Being repealed.	Provisions have been moved to new §§ 925 and 935.
	§ 945	New section.	Provides clarification of provider standards to be met for Medicaid reimbursement and successful provider audits.
§§ 950,960, 970, 980.		Existing sections being repealed.	Provisions have been re-arranged in new sections discussed above.
	§ 990	New section.	Provides for quality management reviews, utilization reviews, and level of care reviews. Some of these reviews by various DMAS staff may result in the recovery of expenditures to providers or in waiver individuals' loss of eligibility for waiver services when they no longer qualify.
	§ 995	New section.	Provides for provider and waiver individual rights of appeal subsequent to DMAS denials of service coverage or recovery demands resulting from provider audits.