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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 30-120-900 et seq.
VAC Chapter title(s)	Waiver Services
Action title	CCC+ Waiver
Date this document prepared	February 26, 2021

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

DMAS has received federal approval to create the Commonwealth Coordinated Care Plus Waiver (CCC+ Waiver). This waiver combines the populations of the Elderly or Disabled with Consumer Direction (EDCD) waiver and Technology Assisted waiver into one waiver, providing home and community-based services to individuals.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

CCC+ = Commonwealth Coordinated Care Plus

DMAS = Department of Medical Assistance Services
EDCD = Elderly or Disabled with Consumer Direction
TECH = Technology Assisted Waiver

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The 2016 Appropriations Act, Item 306.JJJ(3) directed the agency to "seek reforms to include all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems…."

This mandate was carried forward in the 2017 Appropriations Act, Item 306.JJJ(3), the 2018 Appropriations Act, Item 303.SS(3), the 2019 Appropriations Act, Item 303.SS(3).

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The 2016 Appropriations Act, Item 306.JJJ(3) directed the agency to "seek reforms to include all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems…."

This mandate was carried forward in the 2017 Appropriations Act, Item 306.JJJ(3), the 2018 Appropriations Act, Item 303.SS(3), the 2019 Appropriations Act, Item 303.SS(3).

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

DMAS created a new §1915(c) waiver known as the Commonwealth Coordinated Care Plus (CCC+) waiver. These regulations will permit individuals previously served under the EDCD and Technology Assisted waivers to receive home and community-based services to prevent institutionalization while supporting the health, safety, and welfare of individuals. Individuals over the age of 65 or under the age of 65 with a physical disability are the targeted audience for this waiver. Individuals on the CCC+ Waiver may receive services either through the fee for service model or as members of the CCC+ managed care program as part of a fully integrated model across the full continuum of care that includes physical health, behavioral health, the Program for All-Inclusive Care for the Elderly, and institutional services.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The regulations that are affected by this action are the Elderly or Disabled with Consumer Direction Waiver (12 VAC 30-120-900 et seq.) and the Technology Assisted Waiver (12 VAC 30-120-1700).

The CCC+ Waiver combines the EDCD and TECH waivers into one home and community-based waiver to provide access for both populations to additional services to utilize. The regulations for the TECH waiver were incorporated into 12 VAC 30-120-900 et seq., and the combined regulations were updated to ensure access to services and high-quality care.

Virginia was granted authority by the Centers for Medicare and Medicaid (CMS) to mandate the enrollment of eligible individuals into selected managed care plans using a §1915(b) waiver to run concurrently with this waiver authority.

CMS granted authority to DMAS on July 1, 2017 to allow individuals previously served under the EDCD or Technology Assisted waiver to be covered under the Commonwealth Coordinated Care Plus Waiver (CCC+ Waiver).

Issues

Identify the issues associated with the regulatory change, 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, include a specific statement to that effect.

The primary advantages of this regulatory action are that the rules guiding the CCC+ Waiver, which have been approved by CMS, will be included in the Virginia Administrative Code for Medicaid providers, Medicaid members, and other stakeholders.

There are no disadvantages to the public, the agency, or the Commonwealth as a result of this regulatory action.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

There are no requirements in these regulations that are more restrictive than federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

No other state agencies or entities are particularly affected by this regulatory change.

No localities are particularly affected as these changes apply statewide.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and	The CCC+ Waiver was designed to be budget neutral. The agency does not project costs, savings, fees, or revenues from this regulatory change

c) whether any costs or revenue loss can be absorbed within existing resources	
For other state agencies: projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	There are no projected costs, savings, fees, or revenues resulting from this regulatory change for other state agencies.
For all agencies: Benefits the regulatory change is designed to produce.	This regulatory action establishes the rules by which the CCC+ Waiver program operates in order to provide clarity to Medicaid providers, Medicaid members, and stakeholders.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	There are no projected costs, savings, fees, or revenues resulting from this regulatory change for localities.
Benefits the regulatory change is designed to produce.	This regulatory action establishes the rules by which the CCC+ Waiver program operates in order to provide clarity to Medicaid providers, Medicaid members, and stakeholders.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Private providers enrolled to provide services in this waiver will be impacted.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Approximately 4,000 providers are enrolled to provide services through this waiver. DMAS does not collect information about the gross annual sales or numbers of employees of these providers but many providers are likely to be small businesses.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	DMAS does not expect any additional administrative costs for the affected providers. The rate methodologies were developed to recognize all provider reasonable costs.
Benefits the regulatory change is designed to produce.	This regulatory action establishes the rules by which the CCC+ Waiver program operates in order to provide clarity to Medicaid providers, Medicaid members, and stakeholders.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no alternatives that will meet the requirements of the General Assembly mandate and the federally approved waiver.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

There are no alternatives that will meet the requirements of the General Assembly mandate and the federally approved waiver.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, indicate whether the regulatory change meets the criteria set out in Executive Order 14 (as amended, July 16, 2018), e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable.

In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, discuss the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation. Also, discuss why the agency's decision, consistent with applicable law, will minimize the economic impact of regulations on small businesses.

This action did not result from either a periodic review or a small business impact review.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Commenter	Comment	Agency response
34 Individuals	The requirement should be removed that individuals who work a minimum of eight hours per week will have their earned income disregarded up to 200% of the SSI income levels.	A specific appropriation from the FY20 General Assembly was passed in order to make this change.
Arlington County DSS	i) Will DMAS recognize as meeting the curriculum requirements for personal care aides courses taken prior to the emergency regulation or will other course work be required? ii) Do the requirements for back-ground checks and reference checks apply to all volunteers or just those that count toward staffing ratios? The use of volunteers from the community contributes to the required person centered approach and if checks are required, which the volunteers may not be able to afford, it is expected that volun-teerism would significantly decline. iii) Are checks required for paid vendors that enter the adult day care facility for entertainment?	i) There has been no change to the initial and ongoing training requirements for personal care aides. Courses taken prior to the emergency regulation meeting the specified requirements are acceptable. ii) Background checks are required for volunteers that provide direct support to members, this includes volunteers that are counted toward staffing ratios. In accordance with VDSS licensing regulations for Adult Day Care Centers, volunteers must be supervised by a staff person who has passed a background check. iii) Background checks are not required for paid vendors that enter the adult day care facility for entertainment.
Individual	It does not make sense that individuals upon reaching the age of 27, lose points on the waiting list and continue to go without waiver services.	This comment does not pertain to the CCC Plus Waiver. The CCC Plus Waiver does not use a waiting list.
State Long-Term Care Ombudsman, DARS	i) In -930(A)(13), please add reference to the Ombudsman. ii) In -920(5), please add to rights section, 'person centered planning'. iii) In -930(H), please add reference to Ombudsman along with appeal rights. iv) Please add clear definition of 'care coordinator' in -924(21)(L).	i) DMAS believes that the Interagency Agreement with which it has entered with the Department of Aging and Rehabilitative Services already accomplishes this. ii) DMAS does not believe that phrase should be included in that location but have included it elsewhere in that section of the regulations. iii) DMAS believes that the Interagency Agreement with which it has entered with the Department of Aging and Rehabilitative Services already accomplishes this. iv) A definition has been added.

DARS	Comments numbered 1-5 and 7-8 concern editorial recommen-dations, COV references, and language consistency across separate regulations.	DMAS concurs with these recommendations and has reflected them in the proposed stage.
	Comment 5: Retain the definition of 'adult foster care'.	DMAS does not refer to 'adult foster care' in the 900 series of regulations for CCC+ Waiver so there is no need to retain the definition.
	Comment 6: DARS recommended that DMAS include in its ongoing LTSS training with affected communities an element about adults and children.	Thank you for this comment.
	Comment 9: Clarify uses of the term 'eligibility' as to when it means financial eligibility or functional/ medical-nursing eligibility.	DMAS has reviewed the regulations and determined that such clarification is not required. Every use of the term 'eligibility' means generic Medicaid eligibility and not functional/medical/nursing eligibility.
	Comment 10: Define 'care coordinator' better.	DMAS has addressed this recommendation in the proposed stage.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

DMAS is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, (iii) the potential impacts of the regulation, and (iv) the agency's regulatory flexibility analysis stated in that section of this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Emily McClellan, DMAS, 600 E. Broad Street, Richmond, VA 23219, 804-371-4300, or Emily.McClellan@dmas.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of this stage of this regulatory action.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

Changes made in the Emergency Regulation:

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
			The name of Part IX in Chapter 12VAC30-120 was changed from "Elderly or Disabled with Consumer Direction Waiver" to the "Commonwealth Coordinated Care Plus Waiver"
12 VAC 30-120-900		Contains definitions for EDCD waiver.	Relevant text from 1700-series sections was moved into section 900. The following definitions were removed: "activities of daily living", "Americans with Disabilities Act", "conservator", "Elderly or Disabled with Consumer Direction Waiver", "health, safety, and welfare standard", "instrumental activities of daily living", "LPN", "live-in caregiver", "long-term care", "Medicare long-term care communication form", "MFP", "personal care agency", "preadmission screening team", "RN", "respite care agency", "transition coordinator", "Virginia Uniform Assessment Instrument". The following definitions were added: "adult", "adult protective services", "agency provider", "applicant", "assess", "assessment", "backup caregiver", "child protective services", "CCC Plus", "congregate living arrangement", "congregate skilled PDN", "consumer-directed attendant", "consumer-directed services facilitator", "cost-effective", "direct medical benefit", "durable medical equipment", "enrollment", "EPSDT", "legally responsible person", "medically necessary", "monitoring", "PAS team", "provider agreement", "skilled private duty nursing". The following definitions were revised: "assistive technology", "barrier crime", "consumer-directed model of service", "direct marketing", "environmental modifications", "individual's representative", "license", "participating provider", "patient pay amount", "personal care attendant", "personal care services", "personal emergency response system", "primary caregiver", "service authorization", "service authorization contractor", "services facilitator". Throughout this project, "Srv Auth" was

			changed to “service authorization.”
12 VAC 30-120-905		Contains waiver description and legal authority for EDCD waiver.	Relevant text from 1700-series sections was moved into section 905. The name and description of the waiver were changed to reflect that these services are offered through either fee for service or the CCC Plus MCOs. The list of facilities where waiver services cannot be provided was updated.
12 VAC 30-120-920		Contains individual eligibility requirements for EDCD waiver.	Relevant text from 1700-series sections was moved into section 920. The list of institutional placements was updated. The PAS Team functions were updated. Information was added about trained primary caregivers. A section on “waiver rights and responsibilities” was added.
12 VAC 30-120-924		Contains covered services and limits on covered services for EDCD waiver.	Relevant text from 1700-series sections was moved into section 924. The list of covered services was updated. The limitation to MFP participants was removed. VAC cross-references were updated. A requirement related to trained primary caregivers was added. A section was added on skilled respite care services. Transition coordination was eliminated, and for transition services, the 12-month limit was removed, and a list of providers was updated. Updates were made to the definition of assistive technology and the individuals who may obtain the service. The cost for AT may not be carried over from one year to the next and the types of unapproved AT was clarified. The list of unapproved items (such as shipping and freight) was clarified.

			A section on “AT exclusions” was added. Language on generators was added to the environmental modifications section. New service limits and exclusions were added. A section was added on skilled private duty nursing.
12 VAC 30-120-925		Contains respite coverage in children's residential facilities in EDCD waiver.	Changing "EDCD" to "CCC Plus" New language was added on assessments and supervisory visits for children’s residential facilities.
12 VAC 30-120-930		General requirements for home and community-based participating providers for EDCD waiver.	Relevant text from 1700-series sections was moved into section 930. New language on criminal history checks was added. New language on RN and LPN training was added.
12 VAC 30-120-935		Contains participation standards for specific covered services for EDCD waiver.	Relevant text from 1700-series sections was moved into section 935. The term CD employee was updated to CD attendant. “Parent” was defined. A limit on payment to family members was added. Section H on consumer-directed services facilitation for personal care and respite was rewritten. A reference to transition coordination was removed. A section on skilled private duty nursing was added.
12 VAC 30-120-945		Contains payment for services rules for EDCD waiver.	Relevant text from 1700-series sections was moved into section 945. Transition services will be reimbursed at the actual cost of the item. There is a $5,000 limit per calendar year for assistive technology and environmental modifications.
12 VAC 30-120-1700		Contains definitions for Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
12 VAC 30-120-1705		Contains waiver description and legal authority for Technology Assisted	Relevant text was moved into 900-series sections. Section repealed.

		Individuals Waiver.	
12 VAC 30-120-1710		Contains individual eligibility requirements and preadmission screening rules for Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
12 VAC 30-120-1720		Contains covered services, limits, and changes to or termination of Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
12 VAC 30-120-1730		Contains general requirements for participating providers of Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
12 VAC 30-120-1740		Contains participation standards for provision of services for Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
12 VAC 30-120-1750		Contains payment for services rules for Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
12 VAC 30-120-1760		Contains quality management reviews, utilization reviews, and level of care reviews for Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
12 VAC 30-120-1770		Contains appeals rules (provider and recipient) for Technology Assisted Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.

Additional changes made in the Proposed Stage Regulation

Current section number	**New section number, if applicable**	**Current requirement**	**Change, intent, rationale, and likely impact of new requirements**
Through-out			The term “DMAS-designated entity” is changed to “managed care organization” for sake of clarity. The term “skilled” is removed when used with regard to private duty nursing. The term “PAS team” is replaced with “LTSS Screening Team.” The term “timesheet” is replaced with “work shift entry.” Clarification is added that copied or re-dated notes are not acceptable.
			Slash removed from “eating/feeding” in definition of “Activities of Daily Living.”

			Added home and community based setting requirements to definition of "adult day health care." Definition of "adult protective services" linked to definition in the Code of Virginia. Definition of "backup plan" added. Definition of "care coordinator" added. Definition of "child protective services" linked to definition in the Code of Virginia. Specialized care nursing facilities and long stay hospitals added to definition of "Commonwealth Coordinated Care Plus program." Definition of "community based team" added. Definition of "conservator" is removed. In the definition of "consumer-directed attendant" the word "three" is changed to "two." The definition of "DARS" is removed. The definition of "EPSDT" was amended to refer to federal regulations. The terms "financial and categorical" are added to describe the eligibility requirements in the definition of "enrollment." Definition of "local department of social services" added. Definition of "LTSS screening" added. Definition of "LTSS screening team" added. Definition of "managed care organization" was added. Definition of "minor child" added. Definition of "person-centered planning" added.

			The word “unpaid” added to definition of “primary caregiver” and clarification added that paid and unpaid caregivers must be identified in the individual’s record. The phrase “including an MCO” was added to the definition of “service authorization contractor.” Definition of “state fiscal year” added. Definition of “waiver individual” added.
12 VAC 30-120-905			The last sentence of paragraph E is changed to replace “skilled or intermediate” care nursing facilities with “specialized” care nursing facilities and general acute care hospitals are removed. A new section related to DMAS responsibilities is added in paragraph G. A sentence related to appeal rights is added to paragraph H.
12 VAC 30-120-920			In paragraphs B 2 (a)(1) and B 2 (b)(1), the minimum number of hours was reduced from eight to four in accordance with the 2020 Appropriations Act, Special Session 1, Item 313.QQQQ. A new paragraph C 11 is added related to the backup plan. A new E 3 e is added related to privacy, dignity, and respect.
12 VAC 30-120-924			“Nursing facility, specialized care nursing facility, or long-stay hospital” are added to paragraph A 1. A new paragraph B 1 c is added related to the backup plan. Paragraph D 2 g is removed as it relates to services provided under the EPSDT benefit, which is not relevant here. Paragraph E 1 clarifies that respite care may be provided in children’s residential facilities. In Paragraph E 5 a and H 4 a, limits were changed from state fiscal year to calendar year.

			Paragraph G 3 d is removed as it relates to services provided under the EPSDT benefit, which is not relevant here. Paragraph I 1 a is updated to reflect that PERS is authorized when the individual's health, safety, and welfare cannot be ensured. Paragraph J 2 is updated to clarify when transition service is available. Paragraph K 4 e is added to clarify that assistive technology must be provided in the least expensive manner. Paragraph K 4 j (4) is updated to clarify that duplication of AT in the same house or congregate living arrangement is prohibited when such product can be used for a communal purpose. Paragraph L 1 is updated to clarify that environmental modifications do not include general repairs to a residence or vehicle. The word "non-portable" was also added. Paragraph L 3 f is updated to clarify that environmental modifications must be provided in the least expensive manner. Paragraph L 3 i is updated to clarify that vehicle leases are not covered. The word "non-portable" was added to paragraph L 4 a. Paragraph L 4 c is updated to clarify that educational items and hot tubs are not covered. A new paragraph L 4 g is added to clarify that environmental modifications shall not be covered if items are available through other Medicaid services, such as durable medical equipment. Paragraph M 3 is updated to clarify that private duty nursing is limited to 112 hours per week. Paragraph M 6 is updated to indicate that private duty nursing for individuals

			younger than 21 is available only through the EPSDT benefit. Paragraph M 9 b is updated to clarify that respite or personal care may be provided sequentially or alternately when provided to a person receiving private duty nursing.
12 VAC 30-120-925			Paragraph B 2 was added to clarify that respite in a children's facility needs to document the arrival and departure times of the individual, and not staff.
12 VAC 30-120-927			Section 927 is added to the proposed stage regulatory action. (This section was not included in the emergency regulation.) The only change is from "preadmission" screening to "LTSS" screening.
12 VAC 30-120-930			A new paragraph A is added related to VDH licensure or certification of agency-directed services. Record retention is moved to paragraph B 12 c. Volunteers are added to the background check requirements in paragraph B 19 a (1) and (2). Paragraph B 20 is updated to reflect the discussion of available services. Paragraph I 4 clarifies that when a provider discontinues services in an emergency situation, written notice must be given to the individual, and not just to DMAS or the service authorization contractor. In paragraphs I 4 and I 5, appeal rights do not arise, and that text is stricken. Specialized care nursing facilities and long-stay hospitals are added to paragraphs J 1 and 2. Also, an incorrect reference to A 20 in these paragraphs was corrected to A 19. Paragraph J 5 b is updated to reflect that training must be documented. An incorrect reference to A 20 in paragraph J 6 3 was corrected to A 19.

12 VAC 30-120-935			Paragraph B is rewritten to clarify the prohibition on service provision by spouses, parents, and family members. Paragraph D is added to clarify that reimbursement is only available if the provider is with the individual and is awake. Paragraph E is added with a limit of 16 hours of personal care and respite services per day. Paragraph G and its subparagraphs are updated to clarify the enrollment process as an adult day health center. Paragraph G 6 d is added to clarify that AT and EM providers must retain documentation to support costs. Paragraph G 7 is updated to point to existing text on transition services. Paragraph G8 and its subparagraphs insert new text about private duty nursing.
12 VAC 30-120-945			A second sentence was added to paragraphs B 2 in response to the 2021 Appropriations Act, Special Session 1, Item 313.ZZZZ, and 2021 Appropriations Act. Paragraph B 4 b is added to clarify that the dollar limit applies if the individual moves to a different waiver.