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Final 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)	Waivered Services
Action title	CCC+ Waiver
Date this document prepared	7/11/2023

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), 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
CMS = Centers for Medicare & Medicaid Services
DMAS = Department of Medical Assistance Services
EDCD = Elderly or Disabled with Consumer Direction
TECH = Technology Assisted Waiver

Statement of Final Agency Action

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 taking the action; and 3) the title of the regulation.

As of July 11, 2023, DMAS hereby approves the foregoing Regulatory Review Summary entitled "CCC+ Waiver" and adopt the action stated therein. DMAS certifies that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

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.

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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 is 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 through managed care 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 with 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 & 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

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, 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

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, 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.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency's 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
Individual	The commenter notes that her husband is disabled and currently receives services through the waiver. She does not support service facilitators being in their home due to COVID, flu and the fact that they just recently had a baby. They do not want people unnecessarily accessing their home.	Thank you for your concern. During the State Public Health Emergency, the Governor's Executive Order (EO) 51 authorized DMAS to waive enforcement of the some of the agency's regulatory requirements. The Department waived its regulatory requirements for service facilitation and allowed service facilitators to perform the required 90-day visits via telehealth (which included telephone and audio/visual) in lieu of face-to-face contact. This flexibility was necessary in the initial phases of the pandemic to ensure continuity of care while promoting social distancing and maintaining the health and safety of individuals and providers. When the State PHE ended and EO 51 expired, the Department exercised discretion to temporarily continue the flexibility as a transition period for providers and members. On November 19, 2021, the Department released a Medicaid Bulletin continuing the period of non-enforcement as the Commonwealth was in its last phase of the pandemic. However, the Department was made aware of reports of health, safety, and/or welfare concerns from Medicaid members who utilize a number of waiver and state plan services that have not been seen face-to-face for an extended period of time. Face-to-face visits are integral in ensuring the health and safety of Medicaid Members receiving home and community-based services. Therefore, effective January 1, 2023, the Department reinstated the enforcement of regulations related to face-to-face visits for services facilitation. Therefore, this comment did not bring about any revisions to the CCC Plus Waiver Regulations.
Individual	The commenter suggests making it clear that service facilitators are only required to visit every 3 months and not every month.	The regulations allow for this flexibility. While the visits can be conducted every month, there is no requirement that all individuals must receive a monthly visit. The Department does not find it necessary to add clarification.
Individual	The commenter:	(1) Thank you for your comment. This is an existing state requirement for private duty

	(1) asks why the backup caregiver has to be without compensation. (2) states that Assistive Technology and Environmental modifications are in both this waiver and DD Waiver; however, there are differences in their rules and asks that these rules look more like DD Waiver. (3) states that the definition of monitoring conflicts with other language in how they can be performed; (4) asks why there is language about VDSS licensed assisted living facilities with 4 or less people when the commenter has heard that VDSS doesn't license assisted living facilities with 4 or less people. (5) asks where the requirements are for EVV? (6) recommends loosening the requirements of PERS because the language refers to outdated technology and does not consider modern technology like cell phones. (7) asks why a person can't receive PERS and personal care supervision and what if they self-install PERS (8) asks why a family member or a roommate can't provide PDN (9) seeks clarification on whether family members who provide personal care or respite can sign their own forms and timesheets (10) asks why LPNs are allowed to do visits if a RN has to come behind them for another visit (11) asks why the SF management visit has to be done face-to-face in this waiver since it's allowed over the telephone in DD Waiver	nursing in accordance with VAC 12VAC 30-120-1700. (2) There are slight differences, but the core Assistive Technology and Environmental Modifications rules are the same between the CCC Plus and DD Waiver. No revisions to the regulations are necessary. (3) Thank you for your comment. The Department does not find it necessary to add clarification to this definition. (4) Thank you for your comment; upon the review of the VDSS ALF licensing regulations, there is no mention of bed capacity to receive a license. No revisions to the regulations are necessary. (5) EVV requirements are located at 12VAC30-60-65. Also, throughout the regulations, the Department updated references to "timesheets" to "work shift entries" to align with EVV terminology. (6) The language in the regulations does not prohibit use of modern technology. No revisions to the regulations are necessary. (7) The Department neither has the authority nor appropriations to make changes at this time, so no revisions to the regulations are necessary. (8) PDN includes in-home nursing services provided for individuals enrolled in the CCC Plus waiver who have a serious medical condition and/or complex health care need. Because the individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis, it must be performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse. Individuals are required to have an untrained back-up to cover non-staff hours. A family member or a roommate could fulfil that role. (9) Staff that provide direct care for a waiver individual can't sign their own forms and timesheets. No revisions to the regulations are necessary.

	(12) suggests that when a SF business closes, that they should be allowed to send their records to DMAS in some form	(10) LPNs are permitted to make visits that occur between the required 90-day visits. No revisions to the regulations are necessary. (11) The DD Waiver regulations do not contain a reference allowing the SF management visits to be conducted over the telephone. No revisions to the regulations are necessary. (12) Thank you for your suggestion. Record retention requirements are outlined in 12VAC30-120-930. The Department neither has the authority nor appropriations to make changes at this time, so no revisions to the regulations are necessary.

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. 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. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

No changes have been made since the Proposed Stage Regulation.

Detail of All Changes Proposed in this Regulatory Action

*List all changes proposed in this action and the rationale for the changes. 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. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

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 VACS 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 Individuals Waiver.	Relevant text was moved into 900-series sections. Section repealed.
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	Relevant text was moved into 900-series sections. Section repealed.

		Assisted Individuals Waiver.	
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.