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MEMORANDUM

TO: **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Davis Creef**
Assistant Attorney General
Office of the Attorney General

DATE: **December 2, 2021**

SUBJECT: **Proposed Regulation – Commonwealth Coordinated Care Plus Waiver**

You have asked the Office of the Attorney General to review and determine if Department of Medical Assistance Services has the statutory authority to promulgate these regulations and if they comport with applicable state law. I have reviewed the attached proposed regulations posted to the Virginia Regulatory Town Hall that would implement the Commonwealth Coordinated Care Plus Waiver (CCC+ Waiver). The proposed regulations are intended to replace existing emergency regulations.

Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act, and has not exceeded that authority. The proposed regulations will enable the Director to implement the CCC+ Waiver, consistent with the authority set forth in Virginia Code § 32.1-324 and the directives in Item 306.JJJ(3) of the 2016 Appropriation Act, Item 306.JJJ(3) of the 2017 Appropriation Act, Item 303.SS(3) of the 2018 Appropriation Act, and Item 303.SS(3) of the 2019 Appropriation Act.

If you have any questions or need additional information about these regulations, please contact me at 786-6522.

cc: Kim F. Piner, Esq.

Attachment

Proposed Text

highlight

Action: CCC Plus WAIVER
Stage: Proposed 12/2/21 9:54 AM [latest]

12VAC30-120-900 Definitions
Part IX
~~Elderly or Disabled with Consumer Direction~~ Commonwealth Coordinated Care Plus Waiver

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

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

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

"Adult day health care " or "ADHC" means ~~long-term maintenance or supportive services offered by a DMAS-enrolled community-based day care program providing~~ a program licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC) and authorized as a Medicaid-enrolled provider meeting Home and Community Based Services (HCBS) settings rules, and that provides a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility (NF). ~~The program shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC). The services offered by the center shall be required by the waiver individual in order to permit the individual to remain in his home rather than entering a nursing facility.~~ ADHC can also refer to the center where this service is provided.

"Adult Protective Services" or "APS" means the same as defined in §63.2-100 of the COV.

"Agency-directed model ~~of service~~" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes for personal and respite care.

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

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

"Annually" means a period of time covering 365 consecutive calendar days or 366 consecutive days in the case of leap years.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 et seq. and 12VAC30-20-500 through ~~12VAC30-20-560~~ 12VAC30-20-570.

"Applicant" means an individual, or representative on the individual's behalf, who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to the CCC Plus Waiver.

"Assess" means to evaluate an applicant's or an individual's condition, including functional status (an individual's degree of dependence in performing ADLs or IADLs), current medical status, psycho-social history, and environment. Information is collected from the applicant or individual; applicant's or individual's representative, family, and medical professionals as well as the assessor's observation of the applicant or individual.

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

"Assistive technology" or "AT" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that (i) enable ~~waiver~~ individuals ~~who are participating in the Money Follows the Person demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.)~~ to increase their abilities to perform ~~activities of daily living or~~ ADLs or IADLs and to perceive, control, or communicate with the environment in which ~~they~~ the individuals live~~,~~ or ~~that~~ (ii) are necessary to the proper functioning of the specialized equipment.

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

"Backup plan" means a secondary network of supports to perform the duties needed by the waiver individual to ensure the individual's health, safety, and welfare should the paid caregiver be unable to provide such services. All waiver individuals are required to have a backup plan prior to initiation of services and ongoing, which shall be documented in the waiver individual's records. Those listed in the backup plan shall be trained in the skilled needs and technologies required by the waiver individual.

"Barrier crime" means those crimes as defined at § ~~32.1-162.9:1~~ 19.2-392.02 of the Code of Virginia that would prohibit either the employment or the continuation of employment if a person is found, through a Virginia State Police criminal record check, to have been convicted of such a crime.

"Care coordinator" means a professional from one of the state's contracted managed care organizations who assists assigned individuals enrolled in the CCC Plus integrated care initiative by performing care management as defined in 12VAC30-121-20.

"CD" means consumer-directed.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Child Protective Services" or "CPS" means ~~a program overseen by the Virginia Department of Social Services that investigates reports of abuse, neglect, and exploitation of children younger than 18 years of age and provides services when persons are found to be in need of protective services~~ the same as defined in § 63.2-100 of the COV.

"Cognitive impairment" means a severe deficit in mental capability that affects a waiver individual's areas of functioning such as thought processes, problem solving, judgment, memory, or comprehension that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

"Commonwealth Coordinated Care Plus Program" or "CCC Plus" means the DMAS mandatory integrated care initiative for certain qualifying Medicaid members, including members who are dually eligible for Medicare and Medicaid and members receiving long-term services and supports (LTSS). The CCC Plus program includes members who receive services through nursing facility (NF) care, specialized care NF, or long-stay hospitals, or from one of the four DMAS home and community-based services (HCBS) § 1915(c) waivers. Not all individuals in the CCC Plus Program will qualify for the CCC Plus waiver.

"Community-based team" or "CBT" means the same as defined in 12 VAC 30-60-301.

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

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

"Consumer-directed attendant" means a person who provides, via the consumer-directed model of services, personal care~~, companion services,~~ or respite care, or any combination of these ~~three~~ two services, and who is also exempt from workers' compensation.

"Consumer-directed ~~(CD) model of service~~" or "CD" means the model of service delivery for which the individual ~~enrolled in the waiver~~ or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of the attendant or attendants who render the services that are reimbursed by DMAS.

~~"Consumer-directed services facilitator," "CD services facilitator," or "facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the consumer-directed services plan of care, providing attendant management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services.~~

“Critical incident” means any incident that threatens or impacts the well-being of a waiver individual. Critical incidents shall include, but are not limited to, the following incidents: medication errors, severe injury or fall, theft, suspected mental or physical abuse or neglect, financial exploitation, and death.

~~"DARS" means the Department for Aging and Rehabilitative Services.~~

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

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

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

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

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

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

~~"Elderly or Disabled with Consumer Direction Waiver" or "EDCD Waiver" means the CMS-approved waiver that covers a range of community support services offered to waiver individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.~~

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer-directed model of service delivery. The EOR may be the individual ~~enrolled in the waiver~~, a family member, caregiver, or another person.

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

"Environmental modifications" or "EM" means physical adaptations to an individual's primary ~~home~~ residence or primary vehicle ~~or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 1201 et seq.), which~~ that are necessary to ensure the individual's health ~~and~~, safety, ~~or~~ and welfare or

that enable ~~functioning~~ the individual to function with greater independence and shall be of direct medical or remedial benefit to individuals ~~who are participating in the Money Follows the Person demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.)~~. Such physical adaptations shall not be authorized for Medicaid payment when the adaptation is being used to bring a substandard dwelling up to minimum habitation standards.

"Early Periodic Screening, Diagnosis and Treatment" or "EPSDT" means the benefit program administered by DMAS for those younger than 21 years of age in accordance with the definition set forth at 42 CFR 440.40 (b) and the requirements of 42 CFR 441. Subpart B.

"Fiscal/employer agent" or "F/EA" means a state agency or other entity as determined by DMAS that meets the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act, § 2.2-4300 et seq. of the Code of Virginia.

"Guardian" means a person appointed by a court to manage the personal affairs of an incapacitated individual pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 of the Code of Virginia.

"Health, safety, and welfare ~~standard~~" means, for the purposes of this waiver, that an individual's right to receive ~~an EDCD~~ a CCC Plus Waiver service is dependent on a determination that the waiver individual needs the service based on appropriate assessment criteria and a written plan of care, including having a backup plan of care, that demonstrates medical necessity and that services can be safely provided in the community or through the model of care selected by the individual.

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

~~"Individual" or "waiver individual" means the person who has applied for and been approved to receive these waiver services.~~

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

"Institution" means a nursing facility, specialized care nursing facility, or long-stay hospital. Individuals who receive enrollment in the CCC Plus Waiver are deemed to meet the level of care necessary for residence in one of these institutions or are anticipated to need to be in one of these institutions within the next 30 days without the services of the waiver.

"Level of care" or "LOC" means the specification of the minimum amount of assistance an individual requires in order to receive services in an institutional setting under the State Plan or to receive waiver services.

"License" means proof of official or legal permission issued by the government for an entity or person to perform an activity or service ~~such that, in the absence of an official license, the entity or person is debarred from performing the activity or service~~.

"Licensed Practical Nurse" or "LPN" means a person who is licensed or holds multi-state licensure to practice nursing pursuant to Chapter 30 (§ 54.1-3000 et

seq.) of Title 54.1 of the Code of Virginia.

~~"Live-in caregiver" means a personal caregiver who resides in the same household as the individual who is receiving waiver services.~~

"Local department of social services" or "LDSS" means the entity established under § 63.2-324 of the Code of Virginia by the governing city or county in the Commonwealth.

"Long-term ~~care"~~ services and supports" or ~~"LTC"~~ "LTSS" means a variety of services that help individuals with health or personal care needs and activities of daily living over a period of time. Long-term care can be provided in the home, in the community, or in various types of facilities, including nursing facilities and assisted living facilities.

"LTSS screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for screening for certain long-term care services and supports requiring nursing facility eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based care for those individuals who meet nursing facility level of care.

“LTSS Screening Team” means the entity contracted with DMAS that is responsible for performing the screening process pursuant to § 32.1-330 of the Code of Virginia.

"Managed Care Organization" or “MCO” means the same as the definition of this term in 42 CFR 438.2

"Medicaid Long-Term ~~Care (LTC)~~ Services and Supports (LTSS) Communication Form" or "DMAS-225" means the form used by the long-term care provider to report information about changes in an individual's eligibility and financial circumstances.

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

"Medication monitoring" means an electronic device, which is only available in conjunction with ~~Personal Emergency Response Systems~~ personal emergency response systems, that ~~enables certain waiver individuals~~ reminds an individual ~~who are at risk of institutionalization to be reminded~~ to take ~~their~~ medications at the correct dosages and times.

"Minor child" means an individual who is younger than 18 years of age.

~~"Money Follows the Person" or "MFP" means the demonstration program, as set out in 12VAC30-120-2000 and 12VAC30-120-2010.~~

"Monitoring" means the ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the waiver individual's plan of care and effectively meet the individual’s needs, thereby assuring the

individual's health, safety, and welfare. Monitoring activities may include telephone contact; observation; interviewing the individual or the trained individual representative, as appropriate, in person or by telephone; or interviewing service providers.

"Nurse supervisor" means a registered nurse (RN) or licensed professional nurse (LPN) hired or contracted by an agency to provide the supervisory responsibilities as outlined in the waiver to the agency's staff who perform personal care or respite care services to waiver individuals.

"Participating provider" or "provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement~~, including managed care organizations,~~ with DMAS or a managed care organization that has a signed contract with DMAS.

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

"Patient pay amount" means the portion of the individual's income that must be paid as ~~his~~ the individual's share of the long-term ~~care~~ services and supports and is calculated by the local department of social services based on the individual's documented monthly income and permitted deductions.

"Person-centered planning" means a fundamental process that focuses on what is important to and for an individual and the needs and preferences of the individual to create a Plan of Care.

~~"Personal care agency" means a participating provider that provides personal care services.~~

"Personal care aide" or "aide" means a person employed by an agency who provides personal care or unskilled respite services. The aide shall have successfully completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities as further set out in 12VAC30-120-935. Such successful completion may be evidenced by the existence of a certificate of completion issued by the training entity, which is provided to DMAS during provider audits~~, issued by the training entity~~.

"Personal care attendant," or "attendant," or "PCA" means a person who provides personal care or respite services that are directed by ~~a consumer, family member/caregiver, or~~ an employer of record under the CD model of service delivery.

"Personal care services" or "PC services" means a range of support services ~~necessary to enable the waiver individual to remain at or return home rather than enter a nursing facility and~~ that includes assistance with ~~activities of daily living (ADLs), instrumental activities of daily living (IADLs)~~ ADLs or IADLs, access to the community, self-administration of medication~~,~~ or other medical needs, ~~supervision,~~ and the monitoring of health status and physical condition~~.~~ ~~Personal care services shall be~~ provided ~~by aides, within the scope of their licenses/certificates, as appropriate, under~~ through the agency-directed ~~model~~ or ~~by personal care attendants under the CD~~ consumer-directed model of service ~~delivery~~. Personal care services shall be provided by aides or attendants within the scope of their licenses or certifications, as appropriate.

"Personal ~~emergency response system"~~ Emergency Response System" or "PERS" means an electronic device and monitoring service that enables certain waiver individuals, who are at least 14 years of age~~,~~ and at risk of institutionalization to secure help in an emergency. ~~PERS services shall be limited to those waiver individuals who live alone or who are alone for significant parts of the day and who have no regular caregiver for extended periods of time.~~

"PERS provider" means a certified home health or a personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the responsibility to furnish, install, maintain, test, monitor, and service PERS equipment, direct services (i.e., installation, equipment maintenance, and services calls), and PERS monitoring. PERS providers may also provide medication monitoring.

"Plan of care" or "POC" means the written plan developed collaboratively by the waiver individual and the waiver individual's ~~family/caregiver~~ family or caregiver, as appropriate, and the provider related solely to the specific services necessary for the individual to remain in the community while ensuring ~~his~~ the individual's health, safety, and welfare.

~~"Preadmission screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening for certain long-term care services and supports requiring NF eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet individual needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based care for those individuals who meet nursing facility level of care.~~

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

~~"Primary caregiver" means the person who consistently assumes the primary role of providing direct care and support of the waiver individual to live successfully in the community without receiving compensation for providing such care. Such person's name, if applicable, shall be documented by the RN or services facilitator in the waiver individual's record. Waiver individuals are not required to have a primary caregiver in order to participate in the EDCD waiver.~~

"Private duty nursing services" or "PDN" means skilled in-home nursing services listed in the POC that are (i) not otherwise covered under the State Plan for Medical Assistance home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, respectively.

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

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

~~"Respite care agency" means a participating provider that renders respite services.~~

"Respite services" means services provided to waiver individuals ~~who are unable to care for themselves~~ that are furnished on a short-term basis because of the absence of or need for the relief of the unpaid primary caregiver who normally provides the care.

"Service authorization" ~~or "Srv Auth"~~ means the process of approving ~~either~~ a service for the individual. The process of approving is done by DMAS, its service authorization contractor, or an MCO ~~DMAS-designated entity, for the purposes of reimbursement for a service for the individual before it is rendered or reimbursed~~.

"Service authorization contractor" means DMAS or the entity that has been contracted by DMAS, including an MCO, to perform service authorization for medically necessary Medicaid covered home and community-based services.

"Services facilitation" means a service that assists the waiver individual (or ~~family/caregiver~~ family, caregiver, or EOR, as appropriate) in arranging for, directing, training, and managing services provided through the consumer-directed model of service.

~~"Services facilitator" means a DMAS-enrolled provider, a DMAS-designated entity, or a person who is employed or contracted by a DMAS-enrolled services facilitator that is responsible for supporting the individual and the individual's family/caregiver or EOR, as appropriate, by ensuring the development and monitoring of the CD services plans of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services. Services facilitator shall be deemed to mean the same thing as consumer-directed services facilitator.~~

"Skilled private duty nursing services" or "skilled PDN" means skilled in-home nursing services listed in the POC that are (i) not otherwise covered under the State Plan for Medical Assistance home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, respectively).

"Skilled respite services" means temporary skilled nursing services that are provided to waiver individuals ~~who need such services~~ and that are performed by a LPN or RN for the relief of the unpaid primary caregiver who normally provides the care.

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

~~"Transition coordinator" means the person defined in 12VAC30-120-2000 who facilitates MFP transition.~~

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

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

"VDH" means the Virginia Department of Health.

"VDSS" means the Virginia Department of Social Services.

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional ~~comprehensive~~ assessment that is completed by the ~~Preadmission Screening Team~~ screening entity ~~or approved hospital discharge planner~~ that assesses an individual's physical health, mental health, and ~~psycho/social~~ psycho-social and functional abilities to determine if the individual meets the nursing facility level of care.

"Waiver individual" or “individual” means the person who has applied for and been approved to receive these waiver services.

"Weekly" means a span of time covering seven consecutive calendar days.

12VAC30-120-905 Waiver description and legal authority

A. The ~~Elderly or Disabled with Consumer Direction (EDCD)~~ Commonwealth Coordinated Care Plus (CCC Plus) Waiver operates under the authority of § 1915 (c) of the Social Security Act and 42 CFR 430.25(b), which permit the waiver of certain State Plan requirements. These federal statutory and regulatory provisions permit the establishment of Medicaid waivers to afford the states with greater flexibility to devise different approaches to the provision of long-term ~~care (LTC)~~ services and supports. Under this § 1915(c) waiver, DMAS waives § 1902(a)(10)(B) and (C) of the Social Security Act related to comparability of services.

B. ~~This waiver provides Medicaid individuals who are elderly or who have a disability with supportive services to enable such individuals to remain in their communities thereby avoiding institutionalization.~~ CCC Plus Waiver services shall be covered only for Medicaid-eligible individuals who have been determined eligible to require the level of care provided in either a nursing facility, specialized care nursing facility, or long-stay hospital. These services shall be the critical service necessary to delay or avoid the individual's placement in an appropriate facility.

C. Federal waiver requirements provide that the current aggregate average cost of care fiscal year expenditures under this waiver shall not exceed the average per capita expenditures in the aggregate for the level of care (LOC) provided in a nursing facility (NF), specialized care nursing facility, or long-stay hospital under the State Plan that would have been provided had the waiver not been granted.

D. DMAS shall be the single state agency authority, pursuant to 42 CFR 431.10, responsible for the processing and payment of claims for the services covered in this waiver and for obtaining federal financial participation from CMS.

E. Payments for ~~EDCD~~ CCC Plus Waiver services shall not be provided to any financial institution or entity located outside of the United States pursuant to § 1902(a)(80) of the Social Security Act. Payments for ~~EDCD~~ CCC Plus Waiver services furnished in another state shall be (i) provided for an individual who meets the requirements of 42 CFR 431.52 and (ii) limited to the same service limitations that exist when services are rendered within the Commonwealth's political boundaries. Waiver services shall not be ~~furnished to~~ covered for Medicaid-eligible individuals who are inpatients of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), ~~inpatient rehabilitation facility~~ rehabilitation hospitals, assisted living facility licensed by VDSS that serves five or more ~~individuals~~ persons, long-stay

hospitals, specialized care nursing facilities, adult foster homes, or ~~a~~ group ~~home~~ homes licensed by DBHDS.

F. An individual shall not be simultaneously enrolled in more than one waiver program but may be listed on the waiting list for another waiver program as long as criteria are met for both waiver programs.

~~G. DMAS shall be responsible for assuring appropriate placement of the individual in home and community-based waiver services and shall have the authority to terminate such services for the individual for the reasons set out below.~~

~~1. Waiver services shall not be reimbursed until the provider is enrolled and the individual eligibility process is complete.~~

~~2. DMAS payment for services under this waiver shall be considered payment in full and no balance billing by the provider to the waiver individual, family/caregiver, employer of record (EOR), or any other family member of the waiver individual shall be permitted.~~

~~3. Additional voluntary payments or gifts from family members shall not be accepted by providers of services.~~

~~4. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794). EDCD services shall not be authorized if another entity is required to provide the services, (e.g., schools, insurance) because these waiver services shall not duplicate payment for services available through other programs or funding streams.~~

G. DMAS shall be responsible for the following:

1. Placing individuals in appropriate services that are home and community-based;

2. Providing reimbursement for waiver services only after the provider is enrolled and the individual's eligibility process is complete;

3. Not duplicating services that are required as a reasonable accommodation as part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794). CCC Plus Waiver services shall not be authorized if another entity is required to provide the services (e.g schools, insurance) because these waiver services shall not duplicate payment for services available through other programs or funding streams; and

4. Ensuring providers meet the following requirements:

a. Providers shall consider DMAS payment for services under this waiver as payment in full and no balance billing from the provider to the individual, any family member, caregiver, or Employer of Record (EOR) of the waiver individual shall be permitted; and

b. Additional voluntary payments or gifts from family members shall not be accepted by providers of services.

H. ~~In the case of termination of home and community-based waiver services by DMAS, individuals shall be notified of their appeal rights pursuant to 12VAC30-110.~~ DMAS, or the designated ~~Srv Auth~~ service authorization contractor~~,~~ or managed care organization shall have the responsibility and the authority to terminate the receipt of home and community-based ~~care~~ waiver ~~services~~

~~by~~ enrollment for the waiver individual for any of the following reasons. Individuals shall be notified of their appeal rights pursuant to 12VAC30-110 et seq.:

1. The home and community-based ~~care~~ waiver services are no longer the critical alternative to prevent or delay institutional placement within 30 days;

2. The waiver individual is no longer eligible for Medicaid;

3. The waiver individual no longer meets the ~~NF~~ LOC criteria required for the waiver;

4. The waiver individual's environment in the community does not provide for ~~his~~ the individual's health, safety, or welfare;

5. The waiver individual does not have a backup plan for services in the event the provider is unable to provide services; or

6. Any other circumstances ~~(including hospitalization)~~ that cause services to cease or be interrupted for more than 30 consecutive calendar days. ~~In such cases, such individuals shall be referred back to the local department of social services for redetermination of their Medicaid eligibility.~~

12VAC30-120-920 Individual eligibility requirements

A. Home and community-based waiver services shall be available through a § 1915(c) waiver of the Social Security Act ~~waiver~~ for the following Medicaid-eligible individuals who have been determined to be eligible for waiver services and to require the level of care provided in a nursing facility (NF), long-stay hospital, or specialized care nursing facility:

1. Individuals who are elderly as defined by § 1614 of the Social Security Act; or

2. Individuals who have a disability as defined by § 1614 of the Social Security Act.

B. The Commonwealth has elected to cover low-income families with children as described in § 1931 of the Social Security Act; aged, blind, or disabled individuals who are eligible under 42 CFR 435.121; optional categorically needy individuals who are aged and disabled who have incomes at 80% of the federal poverty level; the special home and community-based waiver group under 42 CFR 435.217; and the medically needy groups specified in 42 CFR 435.320, 435.322, 435.324, and 435.330.

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

2. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the waiver individual's total income (including amounts disregarded in determining financial eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated

Omnibus Budget Reconciliation Act of 1986. DMAS shall reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For waiver individuals to whom § 1924(d) applies (Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B)), deduct the following in the respective order:

(1) An amount for the maintenance needs of the waiver individual that is equal to 165% of the SSI income limit for one individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for waiver individuals employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI and (ii) for waiver individuals employed at least ~~eight~~ four but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. However, in no case shall the total amount of income (both earned and unearned) that is disregarded for maintenance exceed 300% of SSI. If the waiver individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the waiver individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI;

(2) For a waiver individual with only a spouse at home, the community spousal income allowance is determined in accordance with § 1924(d) of the Social Security Act;

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family is determined in accordance with § 1924(d) of the Social Security Act; and

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under the state law but not covered under the State Plan.

b. For waiver individuals to whom § 1924(d) of the Social Security Act does not apply, deduct the following in the respective order:

(1) An amount for the maintenance needs of the waiver individual that is equal to 165% of the SSI income limit for one individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for waiver individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for waiver individuals employed at least ~~eight~~ four but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case shall the total amount of income (both earned and unearned) that is disregarded for maintenance exceed 300% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI;

(2) For an individual with a family at home, an additional amount for the maintenance needs of the family that shall be equal to the medically needy income standard for a family of the same size; and

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the State Plan.

C. Assessment and authorization of home and community-based waiver services.

1. To ensure that Virginia's home and community-based waiver programs serve only Medicaid eligible individuals who would otherwise be ~~placed~~ supported in a NF, specialized care NF, or long-stay hospital, home and community-based waiver services shall be considered only for individuals who are eligible for admission within 30 calendar days to ~~a NF~~ these institutions. Home and community-based waiver services shall be the critical service to enable the individual to remain at home and in the community rather than being placed in ~~a NF~~ an institution.

2. The individual's eligibility for home and community-based waiver services shall be determined by the ~~Preadmission~~ LTSS Screening Team ~~or DMAS-enrolled hospital provider~~ after completion of a thorough assessment of the individual's needs and available support. If ~~an individual meets NF criteria, and in the absence of community-based services, is at risk of NF placement within 30 days,~~ the individual is determined eligible based on the procedures as outlined in 12VAC30-60-303, the ~~Preadmission~~ LTSS Screening Team ~~or DMAS-enrolled hospital provider~~ shall provide the individual and ~~family/caregiver~~ family or caregiver with the choice of ~~EDCD~~ CCC Plus Waiver services, other appropriate services, ~~NF~~ institutional placement, or Program of All Inclusive Care for the Elderly (PACE) enrollment for people 55 years of age or older~~, where available~~.

3. The ~~Preadmission~~ LTSS Screening Team ~~or DMAS-enrolled hospital provider~~ shall explore alternative settings or services to provide the care needed by the individual. If Medicaid-funded home and community-based ~~care~~ waiver services are selected by the individual ~~and when such services are determined to be the critical services necessary to delay or avoid NF placement~~, the ~~Preadmission~~ LTSS Screening Team ~~or DMAS-enrolled hospital provider~~ shall initiate referrals for such services.

4. Medicaid shall not pay for any home and community-based ~~care~~ waiver services delivered prior to the date the individual ~~establishing~~ establishes Medicaid financial eligibility and ~~prior to~~ the date of the ~~preadmission~~ LTSS screening ~~by the Preadmission Screening Team or DMAS-enrolled hospital provider and~~ with the ~~physician~~ physician's signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96).

5. Before Medicaid shall assume payment responsibility of home and community-based services, service authorization must be obtained from DMAS or the DMAS designated ~~Srv Auth contractor, in accordance with DMAS policy,~~ service authorization contractor for all services requiring service authorization. Providers shall submit all required information to DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor within 10 business days of initiating care or within 10 business days of receiving verification of Medicaid financial eligibility from the local department of social services. If the provider submits all required information to DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor within 10 business days of initiating care, services may be authorized beginning from the date the provider initiated

services but not preceding the date of the physician's signature on the DMAS 96 form. If the provider does not submit all required information to DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor within 10 business days of initiating care, the services may be authorized beginning with the date all required information was received by DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor, but in no event preceding the date of the physician's signature on the DMAS-96 form.

6. Once waiver eligibility has been determined by the ~~Preadmission~~ LTSS ~~Screening Team or DMAS-enrolled hospital provider~~ and referrals have been initiated, the provider or MCO shall submit a Medicaid ~~LTC~~ LTSS Communication Form (DMAS-225) to the local department of social services to determine financial eligibility for the waiver program and any patient pay responsibilities. If the waiver individual ~~who is receiving EDCD Waiver services~~ has a patient pay amount, a provider shall use the electronic patient pay process for the required monthly monitoring of relevant changes. Local departments of social services shall enter data regarding a waiver individual's patient pay amount obligation into the ~~Medicaid Management Information System (MMIS)~~ DMAS system of record at the time action is taken on behalf of the individual either as a result of an application for ~~LTC services~~ LTSS, redetermination of financial eligibility, or reported change or changes in a waiver individual's situation. Procedures for the verification of a waiver individual's patient pay obligation are available in the appropriate Medicaid provider manual.

7. After the provider or MCO has received notification via the DMAS-225 process by the local department of social services and enrollment confirmation from DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor, the provider shall inform the individual ~~or family/caregiver~~ , family, or caregiver so that services may be initiated.

8. The provider or MCO shall be responsible for notifying the local department of social services via the DMAS-225 when there is an interruption of services for 30 consecutive calendar days or upon discharge or transfer from the provider's services.

~~9. Home and community-based care services shall not be offered or provided to any individual who resides in a NF, an ICF/IID, a hospital, an assisted living facility licensed by VDSS that serves five or more individuals, or a group home licensed by DBHDS. Transition coordination and transition services may be available to individuals residing in some settings as approved by CMS through the Money Follows the Person demonstration program.~~

~~10.~~ 9. Certain home and community-based services shall not be available to individuals residing in an assisted living facility licensed by VDSS that serves four or fewer individuals. These services are: respite, PERS, ADHC, environmental modifications and transition services. Personal care services shall be covered for individuals living in these facilities but shall ~~be limited to personal care~~ not ~~to~~ exceed five hours per day. Personal care services shall be authorized based on the waiver individual's documented need for care over and above that which is provided by the assisted living facility.

~~11.~~ 10. Individuals who are receiving Auxiliary Grants shall not be eligible for ~~EDCD~~ CCC Plus Waiver enrollment or services.

11. All individuals shall have a backup plan prior to initiating services and ongoing in cases of emergency or should the provider be unable to render services as

needed. This backup plan shall be shared with the provider at the onset of services and updated with the provider as necessary.

12. Individuals who are receiving PDN waiver services shall have a trained primary caregiver who accepts responsibility for the individual's health, safety, and welfare. This primary caregiver shall be responsible for all hours not provided by an RN or an LPN. The name of the trained primary caregiver shall be documented in the provider's records.

D. Waiver individual responsibilities under the consumer-directed (CD) model.

1. The individual shall be authorized for CD services and the ~~EOR~~ Employer of Record (EOR) shall successfully complete consumer employee management training performed by the ~~CD~~ services facilitator before the waiver ~~individual/EOR~~ individual or EOR shall be permitted to hire a personal care attendant for Medicaid reimbursement. Any services rendered by an attendant prior to dates authorized by Medicaid shall not be eligible for reimbursement ~~by Medicaid~~. Individuals who are eligible for CD services shall have the capability to hire and train their own personal care attendants and supervise the attendants' performance including~~, but not limited to,~~ creating and maintaining complete and accurate ~~timesheets~~ work shift entries. ~~Individuals may have~~ The EOR may be the individual or a family member, caregiver, or another person ~~serve as the EOR~~ designated by the individual to serve on ~~their~~ the individual's behalf.

2. The person who serves as the EOR ~~on behalf of the waiver individual~~ shall not be permitted to be (i) the paid attendant for respite services or personal care services or (ii) the services facilitator.

3. Individuals ~~will acknowledge that they will~~ shall not knowingly continue to accept CD personal care services when the service is no longer appropriate or necessary for their care needs and shall inform the services facilitator. If CD services continue after services have been terminated by DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor, the waiver individual shall be held liable for attendant compensation.

4. ~~Individuals~~ The individual or EOR, as appropriate, shall notify the ~~CD~~ services facilitator of all hospitalizations and admission to any rehabilitation ~~facility, rehabilitation~~ hospital unit, ~~or~~ NF, specialized care NF, or long-stay hospital as soon as possible. Failure to do so may result in the waiver individual being liable for employee compensation.

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

1. Each waiver individual shall receive, and the provider shall provide, the necessary care and services, to the extent of provider availability, to attain or maintain the highest practicable physical, mental, and psycho-social well-being, in accordance with the person-centered planning of the individual's comprehensive assessment and Plan of Care (POC).

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

3. All waiver individuals shall have the right to:

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

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

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

d. Be treated with respect and with due consideration for his or her dignity and privacy;

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

f. The privacy and confidentiality of the individual’s medical and clinical records; and

g. Receive information (such as a handbook or provider directory) in a manner and format that may be easily understood (in prevalent non-English languages and using translation services) and that is readily accessible in accordance with the standards specified in 42 CFR 438.10.

4. The waiver individual, if legally competent, the waiver individual's legal guardian, or the parent of the minor child shall have the right to:

a. Choose whether the individual wishes to receive home and community-based care waiver services instead of institutionalization in accordance with the assessed needs of the individual. The LTSS Screening Team or MCO shall inform the individual of all available waiver service providers in the community in which the waiver individual resides. The waiver individual shall have the option of selecting the provider and services of the individual’s choice. Individuals enrolled in the CCC Plus managed care program shall have the option of selecting a provider in the MCO’s contracted network and services of the individual’s choice. This choice must be documented in the individual's medical record;

b. Choose a primary care physician in the community in which the individual resides;

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

d. Participate in the care planning process, choice, and scheduling of providers and services; and

e. Be provided care with privacy, dignity, and respect at all times.

12VAC30-120-924 Covered services; limits on covered services

A. Covered services in the ~~EDCD~~ CCC Plus Waiver ~~shall include~~ are as follows: adult day health care, personal care (both consumer-directed and agency-directed), respite services (both consumer-directed and agency-directed), PERS services, ~~PERS~~ (including medication monitoring~~,~~) ~~limited~~ services facilitation, private duty nursing, assistive technology, ~~limited~~ environmental modifications, ~~transition coordination,~~ and transition services.

1. The services covered in this waiver shall be appropriate and medically necessary to maintain the individual in the community in order to prevent institutionalization and shall be cost effective in the aggregate as compared to the alternative ~~NF~~ institutional placement.

2. ~~EDCD~~ CCC Plus Waiver services shall not be authorized if another entity is required to provide the services (e.g., schools, insurance). Waiver services shall not duplicate services available through other programs or funding streams.

~~3. Assistive technology and environmental modification services shall be available only to those EDCD Waiver individuals who are also participants in the Money Follows the Person (MFP) demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.).~~

~~4.~~ 3. An individual receiving ~~EDCD~~ CCC Plus Waiver services who is also getting hospice care may receive Medicaid-covered personal care (agency-directed and consumer-directed), respite care (agency-directed and consumer-directed), services facilitation, private duty nursing, adult day health care, transition services, ~~transition coordination,~~ and PERS services, regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. ~~Such dual waiver/hospice individuals shall only be able to receive assistive technology and environmental modifications if they are also participants in the MFP demonstration program.~~

B. ~~Voluntary/involuntary disenrollment~~ Disenrollment from consumer-directed services. In ~~either voluntary or involuntary~~ disenrollment situations, the waiver individual shall be ~~permitted to select an agency from which to receive his~~ offered agency-directed personal care and respite services from a provider of the waiver individual's choice.

1. A waiver individual may be found to be ineligible for CD services by either the ~~Preadmission~~ LTSS Screening Team~~, DMAS-enrolled hospital provider~~, DMAS, its designated agent, or the ~~CD~~ services facilitator. An individual may not begin or continue to receive CD services if there are circumstances where the waiver individual's health, safety, or welfare cannot be assured, including but not limited to:

a. It is determined that the waiver individual cannot ~~be~~ complete the duties of the EOR and no one else is able to assume this role;

b. The waiver individual cannot ensure his own health, safety, or welfare or;

develop an emergency backup plan that will ensure his health, safety, or welfare; or

c. The waiver individual has medication or skilled nursing needs or medical or behavioral conditions that cannot be met through CD services or other services.

2. The waiver individual may be involuntarily ~~disenrolled~~ dis-enrolled from consumer direction if ~~he~~ the individual or the EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's ~~timesheets~~ work shift entries or non-compliance with CD EOR requirements.

3. In situations where either (i) the waiver individual's health, safety, or welfare cannot be assured or (ii) attendant ~~timesheet~~ work shift entry discrepancies are

known, the services facilitator shall assist as requested with the waiver individual's transfer to agency-directed services as follows:

a. Verify that essential training has been provided to the waiver individual or EOR;

b. Document, in the waiver individual's ~~case~~ record, the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator;

c. Discuss with the waiver individual or the EOR, as appropriate, the agency-directed option that is available and the actions needed to arrange for such services and offer choice of potential providers, and

d. Provide written notice to the waiver individual of the right to appeal such involuntary termination of consumer direction. Such notice shall be given at least 10 calendar days prior to the effective date of this change. In cases when the individual's or the provider personnel's safety may be in jeopardy, the 10 calendar ~~days~~ days' notice shall not apply.

C. Adult day health care (ADHC) services. ADHC services shall only be offered to waiver individuals who meet ~~preadmission~~ LTSS screening criteria as established in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom ADHC services shall be an appropriate and medically necessary alternative to institutional care. ADHC services may be offered to individuals in a VDSS-licensed adult day care center (ADCC) congregate setting. ADHC may be offered either as the sole home and community-based ~~care~~ waiver service or in conjunction with personal care (either agency-directed or consumer-directed), respite care (either agency-directed or consumer-directed), or ~~PERS~~ Personal Emergency Response System (PERS). A multi-disciplinary approach to developing, implementing, and evaluating each waiver individual's POC shall be essential to quality ADHC services.

1. ADHC services shall be designed to prevent institutionalization by providing waiver individuals with health care services, maintenance of ~~their~~ the individual's physical and mental conditions, and coordination of rehabilitation services in a congregate daytime setting and shall be tailored to ~~their~~ each individual's unique needs. The minimum range of services that shall be made available to every waiver individual shall be: assistance with ~~ADLs~~ activities of daily living (ADLs), nursing services, coordination of rehabilitation services, nutrition, social services, recreation, and socialization services.

a. Assistance with ADLs shall include supervision of the waiver individual and assistance with management of the individual's POC.

b. Nursing services shall include the periodic evaluation, at least every 90 days, of the waiver individual's nursing needs; provision of indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervision of the waiver individual in self-administered medication; support of families in their home care efforts for the waiver individuals through education and counseling; and helping families identify and appropriately utilize health care resources. Periodic evaluations may occur more frequently than every 90 days if indicated by the individual's changing condition. Nursing services shall also include the general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications.

c. Coordination and implementation of rehabilitation services to ensure the waiver individual receives all rehabilitative services deemed necessary to improve or

maintain independent functioning, to include physical therapy, occupational therapy, and speech therapy.

d. Nutrition services shall be provided to include~~, but not necessarily be limited to,~~ one or more ~~meal~~ meals per day that meets the daily nutritional requirements pursuant to 22VAC40-60-800. Special diets and nutrition counseling shall be provided as required or requested by the waiver ~~individuals~~ individual.

e. Recreation and social activities shall be provided that are suited to the needs of the waiver individuals and shall be designed to encourage physical exercise, prevent physical and mental deterioration, and stimulate social interaction.

f. ADHC coordination shall involve implementing the waiver individuals' POCs, updating such plans, recording 30-day progress notes, and reviewing the waiver individuals' daily logs each week.

2. Limits on covered ADHC services.

a. A day of ADHC services shall be defined as a minimum of six hours.

b. ~~ADCCs~~ ADHCs that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing; or (iv) any other procedures that require sterile technique. The ADCC shall not permit its aide employees to perform skilled nursing procedures.

c. At any time that the center is no longer able to provide reliable, continuous care to any of the center's waiver individuals for the number of hours per day or days per week as contained in the individuals' POCs, then the center shall contact the waiver individuals ~~or family/caregivers~~ , family, caregivers, or MCO care coordinators, as appropriate, to initiate other care arrangements for these individuals. The center may either subcontract with another ADCC or may transfer the waiver individual to another ADCC. The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge, at least 10 calendar days prior to the effective date of the discharge. In cases when the individual's or the center personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.

d. ADHC services shall not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in ~~NFs, ICFs/IID~~ nursing facilities, intermediate care facilities for individuals with intellectual disabilities, hospitals, assisted living facilities that are licensed by VDSS, or group homes that are licensed by DBHDS.

D. Agency-directed personal care services. Agency-directed personal care services shall ~~only~~ be offered to persons who meet the ~~preadmission~~ LTSS screening criteria at 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom it shall be an appropriate alternative to institutional care. Agency-directed personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include~~, but shall not necessarily be limited to,~~ assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and the monitoring of health status and physical condition. Where the individual requires assistance with ADLs, and when specified in the POC, such supportive services may include assistance with IADLs. This

service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part ~~VIII (18VAC90-20-420~~ VI (18VAC90-19-240 through ~~18VAC90-20-460)~~ 18VAC90-19-280) of ~~18VAC90-20~~ 18VAC90-19. Agency-directed personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based ~~care~~ waiver service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS. The provider shall document, in the individual's medical record, the waiver individual's choice of the agency-directed model.

1. Criteria. In order to qualify for this service, the waiver individual shall have met the ~~NF~~ LOC criteria as set out in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 as documented on the UAI assessment form, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be needed if the waiver individual were receiving personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

c. The individual ~~or family/caregiver~~ , family, or caregiver shall have a backup plan or caregiver for the provision of services in the event the agency is unable to provide an aide.

2. Limits on covered agency-directed personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. DMAS or its contractor shall reimburse for services delivered, consistent with the approved POC, for personal care that the personal care aide provides to the waiver individual to assist ~~him~~ while ~~he is~~ at work or postsecondary school or both.

(1) DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that are provided to ~~him~~ the individual in the workplace or postsecondary school or both.

(2) DMAS shall not pay for the personal care aide to assist the ~~enrolled~~ waiver individual with any functions or tasks related to the individual completing ~~his~~ a job or postsecondary school functions or for supervision time during either work or postsecondary school or both.

c. Supervision services shall ~~only~~ be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no ~~one else~~ competent adult in the home ~~competent and~~ able to call for help in case of an emergency.

d. There shall be a maximum limit of eight hours per ~~24-hour~~ day for supervision services. Supervision services shall be documented in the POC as needed by the individual.

e. Agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. ~~Individual exceptions~~ Exceptions may be granted based on criteria ~~established by DMAS~~ set forth in 12VAC30-120-927.

f. Due to the complex medical needs of waiver individuals requiring PDN services and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and shall render the required skilled services during the entire time that the aide is providing unskilled care.

E. Agency-directed respite services. Agency-directed respite care services shall ~~only~~ be offered to waiver individuals who meet the ~~preadmission~~ LTSS screening criteria at 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom it shall be an appropriate alternative to institutional care. Agency-directed respite care services may be either skilled ~~nursing~~ respite or unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include~~, but shall not be limited to,~~ assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and monitoring health status and physical condition. Skilled respite shall include skilled nursing care ordered on the physician-certified POC.

1. Respite care shall only be offered to individuals who have ~~an unpaid~~ an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. Respite care services may be provided in the individual's home or other community settings. Respite shall also be provided in children's residential facilities in accordance with 12VAC30-120-925.

2. When the individual requires assistance with ADLs, and where such assistance is specified in the waiver individual's POC, such supportive services may also include assistance with IADLs.

3. ~~The unskilled care portion of this~~ Unskilled respite service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part ~~VIII (18VAC90-20-420~~ VI (18VAC90-19-240 through ~~18VAC90-20-460)~~ 18VAC90-19-280) of ~~18VAC90-20~~ 18VAC90-19.

4. Skilled respite care services.

a. This service shall be provided by skilled nursing staff licensed to practice in the Commonwealth under the direct supervision of a licensed, certified, or accredited home health agency with which DMAS has a provider agreement to provide PDN. Direct supervision means that the supervising registered nurse (RN) is immediately accessible by telephone to the RN, LPN, or personal care aide who is delivering waiver-covered services to individuals.

b. Skilled respite care services shall be comprised of both skilled and hands-on care of either a supportive or health-related nature and may include all skilled nursing care as ordered on the physician-certified POC, assistance with ADLs or IADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of individuals.

c. When skilled respite services are offered in conjunction with PDN, the same individual record may be used with a separate section for skilled respite services documentation. This documentation must be clearly labeled as distinct from PDN services.

d. Individuals who reside in the same house shall be permitted to share skilled respite care service providers. The same limits on this service in the congregate setting (480 hours per calendar year per household) shall apply regardless of the type of waiver.

~~4.~~ 5. Limits on service.

a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per individual per ~~state fiscal~~ calendar year, to be service authorized. ~~If an individual changes waiver programs, this same maximum number of respite hours shall apply.~~ No additional respite hours beyond the ~~480~~ maximum limit shall be approved for payment for individuals, even those who change waiver programs. Additionally, individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per ~~state fiscal~~ calendar year combined.

b. If agency-directed respite service, is the only service received by the waiver individual, it must be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the provider ~~agency~~ or MCO shall notify the local department of social services for its redetermination of eligibility for the waiver individual.

c. The individual ~~or family/caregiver~~ , family, or caregiver shall have a backup plan or caregiver for the provision of services in the event the agency is unable to provide an aide.

F. Services facilitation for consumer-directed services. Consumer-directed personal care and respite care services shall only be offered to ~~persons~~ waiver individuals who meet the ~~preadmission~~ LTSS screening criteria at 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom there shall be appropriate alternatives to institutional care.

1. Individuals who choose CD services shall receive support from a DMAS-enrolled ~~CD~~ services facilitator or a provider designated by the managed care organization as required in conjunction with CD services. The services facilitator shall document the waiver individual's choice of the CD model and whether there is a need for another person to serve as the EOR on behalf of the individual. The ~~CD~~ services facilitator shall be responsible for assessing the waiver individual's particular needs for a requested CD service, assisting in the development of the POC, providing training to the EOR on ~~his~~ the EOR's responsibilities as an employer, and for providing ongoing support of the CD services.

2. Individuals who are eligible for CD services shall have~~, or have~~ an EOR who has~~,~~ the capability to hire, to ~~and~~ train, and to fire the personal care attendant or attendants and supervise the attendant's performance, including approving the attendant's ~~timesheets~~ work shift entries.

a. If a waiver individual is unwilling or unable to direct ~~his~~ one's own care or is younger than 18 years of age, ~~a family/caregiver/designated person~~ a family, caregiver, or designated person shall serve as the EOR on behalf of the waiver individual in order to perform these supervisory and work shift entry approval functions.

b. Specific employer duties shall include checking references of personal care attendants and determining that personal care attendants meet qualifications.

3. The individual ~~or family/caregiver~~ , family, or caregiver shall have a backup plan or caregiver for the provision of services in case the attendant does not show up for work as scheduled or terminates employment without prior notice.

4. The ~~CD~~ services facilitator shall not be the waiver individual, a CD attendant, a provider of other Medicaid-covered services, the spouse of the waiver individual, parent (natural, adoptive, step, or foster parent) or other legal guardian of the waiver individual who is a minor ~~child,~~ or the EOR who is employing the CD attendant.

5. DMAS or the MCO shall either provide for ~~fiscal employer/agent~~ fiscal/employer agent services or contract for the services of a ~~fiscal employer/agent~~ fiscal/employer agent for CD services. The ~~fiscal employer/agent~~ fiscal/employer agent shall be reimbursed by DMAS or the DMAS contractor ~~(if the fiscal/employer agent service is contracted)~~ to perform certain tasks as an agent for the EOR. The ~~fiscal employer/agent~~ fiscal/employer agent shall handle responsibilities for the waiver individual including~~, but not limited to,~~ payroll, employment taxes and background checks for attendants. The fiscal employer/agent fiscal/employer agent shall seek and obtain all necessary authorizations and approvals of the Internal Revenue Service in order to fulfill all of these duties.

G. Consumer-directed personal care services. CD personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include ~~assistance with ADLs and may include, but shall not be limited to,~~ assistance with ADLs, access to the community, monitoring of self-administered medications or other medical needs, supervision, and the monitoring of health status and physical condition. Where the waiver individual requires assistance with ADLs, and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part ~~VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC 90-20~~ VI (18VAC90-19-240 through 18VAC90-19-280) of 18VAC90-19 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. CD personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based waiver service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS.

1. In order to qualify for this service, the waiver individual shall have met the ~~NF~~ LOC criteria as set out in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 as documented on the UAI assessment instrument, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the waiver individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be otherwise authorized had the individual chosen to receive personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

2. Limits on covered CD personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. There shall be a limit of eight hours per ~~24-hour~~ day for supervision services included in the POC. Supervision services shall be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no ~~one else~~ other competent adult ~~in the home who is competent and~~ able to call for help in case of an emergency.

c. Consumer-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. ~~Individual exceptions~~ Exceptions may be granted based on criteria ~~established by DMAS~~ set forth in 12VAC30-120-927.

d. Due to the complex medical needs of waiver individuals requiring PDN services and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and shall render the required skilled services during the entire time that the attendant is providing unskilled care.

3. CD personal care services at work or school shall be limited as follows:

a. DMAS or its contractor shall reimburse for services delivered, consistent with the approved POC, for CD personal care that the attendant provides to the waiver individual to assist ~~him~~ while ~~he is~~ at work or postsecondary school or both.

b. DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to ~~him~~ the individual in the workplace or postsecondary school or both.

c. DMAS shall not pay for the personal care attendant to assist the waiver individual with any functions or tasks related to the individual completing ~~his~~ a job or postsecondary school functions or for supervision time during work or postsecondary school or both.

H. Consumer-directed respite services. CD respite care services are unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include~~, but shall not be limited to,~~ assistance with ADLs, access to the community, monitoring of self-administration of medications or other medical needs, supervision, monitoring health status and physical condition, and personal care services in a work environment.

1. In order to qualify for this service, the waiver individual shall have met the ~~NF~~ LOC criteria as set out in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 as documented on the UAI ~~assessment instrument~~ form, and for whom it shall be an appropriate alternative to institutional care.

2. CD respite services shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. This service shall be provided in the waiver individual's home or other community settings.

3. When the waiver individual requires assistance with ADLs, and where such assistance is specified in the individual's POC, such supportive services may also include assistance with IADLs.

4. Limits on covered CD respite care services.

a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per waiver individual per ~~state fiscal~~ calendar year. If a waiver individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per ~~state fiscal~~ calendar year combined.

b. CD respite care services shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part ~~VIII (18VAC90-20-420~~ VI (18VAC90-19-240 through ~~18VAC90-20-460)~~ 18VAC90-19-280) of ~~18VAC90-20~~ 18VAC90-19 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia).

c. If consumer-directed respite service is the only service received by the waiver individual, it shall be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the services facilitator or MCO shall refer the waiver individual to the local department of social services for its redetermination of Medicaid eligibility for the waiver individual.

l. Personal emergency response system (PERS).

1. Service description. PERS is a service that monitors ~~waiver individual~~ the individual's safety in the home and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line or system. PERS may also include medication monitoring devices.

a. PERS ~~may~~ shall be authorized only when there is no ~~one else~~ other competent adult in the home ~~with the waiver individual~~ who is ~~competent or continuously~~ available to call for help in an emergency or when the ~~individual is in imminent danger~~ individual's health, safety, and welfare cannot be ensured.

b. The use of PERS equipment shall not relieve the primary or backup caregiver of ~~his~~ the caregiver's responsibilities.

c. Service units and service limitations.

(1) PERS shall be limited to waiver individuals who are ages 14 years and older who also either live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time. PERS shall only be provided in conjunction with receipt of personal care services (either agency-directed or consumer-directed), respite services (either agency-directed or consumer-directed), or adult day health care. A waiver individual shall not receive PERS if ~~he~~ the individual has a cognitive impairment as defined in 12VAC30-120-900.

(2) A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service shall be the one-month rental price set by DMAS in its fee schedule. The one-time installation of the unit shall include installation, account activation, individual and ~~family/caregiver~~ family or caregiver instruction, and subsequent removal of PERS equipment when it is no longer needed.

(3) PERS services shall be capable of being activated by a remote wireless device and shall be connected to the waiver individual's telephone line or system. The PERS console unit must provide hands-free voice-to-voice communication with

the response center. The activating device must be (i) waterproof, (ii) able to automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, (iii) able to be worn by the waiver individual, and (iv) automatically reset by the response center after each activation, thereby ensuring that subsequent signals can be transmitted without requiring manual resetting by the waiver individual.

(4) All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard.

(5) Medication monitoring units shall be physician ordered. In order to be approved to receive the medication monitoring service, a waiver individual shall also receive PERS services. Physician orders shall be maintained in the waiver individual's record. In cases where the medical monitoring unit must be filled by the provider, the person who is filling the unit shall be either an RN or an LPN. The units may be filled as frequently as a minimum of every 14 days. There must be documentation of this action in the waiver individual's record.

J. Transition ~~coordination and transition~~ services. Transition ~~coordination and transition~~ services, as defined at ~~12VAC30-120-2000 and~~ 12VAC30-120-2010, provide for ~~applicants~~ individuals to move from institutional placements or licensed or certified provider-operated living arrangements to private homes or other qualified settings. The ~~applicant's~~ individual's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall ~~coordinate with the transition coordinator to~~ ensure that ~~EDCD~~ CCC Plus Waiver eligibility criteria shall be met.

1. Transition ~~coordination and transition~~ services shall be authorized by DMAS or its designated agent in order for reimbursement to occur.

2. ~~For the purposes of transition services, an institution must meet the requirements as specified by CMS in the Money Follows the Person demonstration program at **http://www.ssa.gov/OP_Home/comp2/F109-171.html#ft262**.~~ To qualify for the service, the waiver individual shall be discharged after 90 consecutive days of residence from an institution, Intermediate Care Facility for Individuals with Intellectual Disabilities, Institution for Mental Disease, or Psychiatric Residential Treatment Facility.

~~3. Transition coordination shall be authorized for a maximum of 12 consecutive months upon discharge from an institutional placement and shall be initiated within 30 days of discharge from the institution.~~

~~4.~~ 3. Transition ~~coordination and transition~~ services shall be provided in conjunction with personal care (agency-directed or consumer-directed), respite (agency-directed or consumer-directed), private duty nursing, or adult day health care services.

4. Transition services may be provided by DMAS enrolled area agencies on aging, centers for independent living, and local departments of social services.

K. Assistive technology (AT).

1. ~~Service description.~~ Assistive technology (AT)~~, as defined in 12VAC30-120-900,~~ shall ~~only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.).~~ be portable and shall be authorized per calendar year. AT services are the specialized medical equipment and supplies, including those devices, controls, or appliances, specified in the individual's plan of care, but that are not available under the State Plan for

Medical Assistance, that enable a waiver individual to increase the individual's ability to perform ADLs or IADLs, or to perceive, control, or communicate with the environment in which one lives.

2. In order to qualify for these services, the individual shall have a demonstrated need for specialized medical equipment and supplies for remedial or direct medical benefit primarily in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. AT shall be covered in the least expensive~~, most cost-effective~~ manner.

3. AT services shall be available for a waiver individual who has a demonstrated need for equipment for remedial or direct medical benefit. This service includes ancillary supplies and equipment necessary for the proper functioning of such items.

~~3.~~ 4. Service units and service limitations.

a. ~~All requests for AT shall be made by the transition coordinator to DMAS or the Srv Auth contractor.~~ The cost for AT shall not be carried over from one calendar year to the next. Each item must be service authorized by either DMAS or the DMAS designated service authorization contractor for each calendar year.

b. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be $5,000 per calendar year for ~~individuals~~ an individual regardless of waiver, or regardless of whether the individual changes waiver programs, for which AT is approved. The service unit shall always be one, for the total cost of all AT being requested for a specific timeframe.

c. AT may be provided in the individual's home or community setting.

d. AT shall not be approved for purposes of convenience of the ~~caregiver/provider~~ caregiver or provider or restraint of the individual, recreation or leisure, educational purposes, or diversion activities.

e. AT shall be carried out in the least expensive manner possible to achieve the goal required for the individual's health, safety, and welfare. AT shall be reimbursed in a manner that is reasonable and customary not to exceed the provider's usual and customary charges to the general public..

~~e.~~f. An independent, professional consultation shall be obtained from a qualified professional who is knowledgeable of that item for each AT request prior to approval by the ~~Srv Auth~~ service authorization contractor or managed care organization and may include training on such AT by the qualified professional. The consultation shall not be performed by the provider of AT to the individual.

~~f.~~g. All AT shall be ~~prior~~ authorized by DMAS or the ~~Srv Auth~~ designated service authorization contractor or managed care organization prior to billing or providing services to the individual.

~~g.~~h. ~~Excluded shall be items~~ Items that are reasonable accommodation requirements~~, for example,~~ of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), ~~or~~ the Rehabilitation Act (20 USC § 794), or ~~that~~ are required to be provided through other funding sources shall be excluded from Medicaid coverage. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the

Americans with Disabilities Act (42 USC §§ 12131 through 12165), Virginians with Disabilities Act (Title 51.5 (51.5-1 et seq.) of the Code of Virginia) or the Rehabilitation Act of 1973 (29 USC § 794).

~~h.~~i. AT services or equipment shall not be rented but shall be purchased.

j. Shipping, freight, or delivery charges ~~are~~ shall not be billable to DMAS or the waiver individual, as such charges are considered non-covered items.

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

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

(3) The service authorization shall not be modified to accommodate delays in product deliveries. In such situations, the provider must seek a new service authorization.

(4) When two or more waiver individuals live in the same home or congregate living arrangement, the AT shall be shared to the extent practicable consistent with the type of AT and the individuals' needs as documented in their POCs. There shall be no duplication of AT in the same house when such product can be used for a communal purpose.

k. Assistive technology shall not be available to individuals younger than 21 years of age through the CCC Plus Waiver. Assistive technology for individuals younger than 21 shall be accessed through the EPSDT benefit.

l. AT exclusions.

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

(2) Providers that supply AT for the waiver individual may not perform assessments, consultations, or write specifications for that individual. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and service authorization by DMAS or the designated service authorization contractor. The vendor shall receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary, then the vendor shall notify the assessor to ensure the changed items meet the individual's needs.

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

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

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

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

L. Environmental modifications (EM).

1. ~~Service description.~~ Environmental modifications (EM)~~, as defined herein in 12 VAC 30-120-900, shall only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.).~~ ~~Adaptations~~ shall consist of adaptations ~~be~~ documented in the waiver individual's POC and may include~~, but shall not necessarily be limited to,~~ the installation of non-portable ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the health, safety, and welfare of the waiver individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, flooring, roof repairs, central air conditioning, or decks. Adaptations that add to the total square footage of the home shall be excluded from this benefit, except when necessary to complete an authorized adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications ~~must~~ shall be prior authorized by the ~~Srv Auth~~ service authorization contractor or managed care organization. Modifications may only be made to a vehicle if it is the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles. This service shall not include general repairs to a residence or vehicle.

2. In order to qualify for these services, the waiver individual shall have a demonstrated need for modifications of a remedial or direct medical benefit offered in ~~his~~ the individual's primary home or primary vehicle ~~used by the waiver individual~~ to ensure ~~his~~ the individual's health, welfare, or safety or specifically to improve the individual's personal functioning. Modifications may include a generator for a waiver individual who is dependent on mechanical ventilation for 24 hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. EM shall be covered in the least expensive~~, most cost-effective~~ manner.

3. Service units and service limitations.

~~a. All requests for EM shall be made by the MFP transition coordinator to DMAS or the Srv Auth contractor.~~

~~b.~~ a. The maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be $5,000 per calendar year for ~~individuals~~ an individual regardless of waiver, or regardless of whether the individual changes waiver programs, for which EM is approved. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

~~c.~~ b. All EM shall be authorized by ~~the Srv Auth contractor~~ DMAS or the DMAS designated service authorization contractor prior to billing or providing services to the individual.

~~d.~~ c. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. ~~Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act,~~

~~the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794).~~

~~e. Transition coordinators shall, upon completion of each modification, meet face-to-face with the waiver individual and his family/caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual.~~

~~f.~~ d. EM shall not be approved for purposes of convenience of the ~~caregiver/provider~~ caregiver or provider or restraint of the waiver individual.

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

f. EM shall be carried out in the least expensive manner possible to achieve the goal required for the individual's health, safety, and welfare.

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

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

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

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

k. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165), the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), or the Rehabilitation Act of 1973 (29 USC § 794).

4. EM exclusions.

a. There shall be no duplication of previous EM services within the same residence such as multiple non-portable wheelchair ramps or previous modifications to the same room.

b. Adaptations or improvements to the primary home that shall be excluded are of general utility and are not of direct medical or remedial benefit to the waiver individual, such as, but not limited to, carpeting; flooring; roof repairs; central air conditioning or heating; general maintenance and repairs to a home; additions or maintenance of decks or fences; maintenance, replacement, or addition of

sidewalks, driveways, or carports; or adaptations that only increase the total square footage of the home.

c. EM shall not be covered by Medicaid for general leisure or diversion items, items that are recreational in nature, items for educational purposes, or items that may be used as an outlet for adaptive or maladaptive behavioral issues. Such non-covered items may include swing sets, playhouses, climbing walls, trampolines, protective matting or ground cover, sporting equipment, hot tubs, or exercise equipment, such as special bicycles or tricycles.

d. EM shall not be covered by Medicaid if~~, for example,~~ payment for such modifications can be made through the Fair Housing Act (42 USC § 3601 et seq.), the Virginia Fair Housing Law (§ 36-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.).

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

f. Providers who supply EM to a waiver individual shall not perform assessments, consultations, or write EM specifications for such individuals

g. EM shall not cover payment for modifications or items that can be made through other Medicaid services, such as durable medical equipment.

M. Private duty nursing. PDN, for a single individual and individuals residing in the same home, as defined in 12VAC30-120-900, shall be provided for individuals who have serious medical conditions or complex health care needs. To receive this service, an individual must require specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by an RN or an LPN. Once waiver eligibility has been determined by the LTSS Screening Team and a determination that the individual requires ongoing skilled nursing care has been made, then the PDN hours shall be authorized by DMAS or the DMAS designated service authorization contractor.

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

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

3. Limits placed on the amount of PDN that will be approved for reimbursement shall be consistent with the individual's support needs and medical necessity but shall not exceed 112 hours per week. The maximum PDN hours authorized per week for individuals shall be based on their technology and documented medical necessity justification.

4. For individuals, whether living separately or in a congregate setting, PDN shall be reimbursed up to a maximum 112 hours per week (Sunday through Saturday) per waiver individual living in the household.

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

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

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

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

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

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

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

(5) Oxygen therapy with documented usage under a physician's order;

(6) Daily tracheostomy care;

(7) Tracheostomy suctioning under a physician's order; and

(8) At risk of requiring subsequent mechanical ventilation.

6. PDN shall not be available to individuals younger than 21 years of age as a waiver service. PDN for individuals younger than 21 shall be accessed through the EPSDT benefit.

7. PDN services may include consultation and training for the primary caregiver.

8. The provider shall be responsible for notifying the LDSS, the service authorization contractor, and the managed care organization should the primary residence of the individual be changed, should the individual be hospitalized, should the individual die, or should the individual be absent from the Commonwealth for 48 hours or more.

9. Exclusions from DMAS coverage of PDN:

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

b. PDN services may be ordered but shall not be provided simultaneously with skilled respite care or personal care services. These services may be provided sequentially or alternately from each other.

c. Providers shall not bill prior to receiving the physician's dated signature on the individual's POC for services provided and DMAS or DMAS designated service authorization contractor’s authorization or determination of PDN hours.

d. Time spent transporting the waiver individual shall not be reimbursed by DMAS.

e. DMAS shall not reimburse for PDN services through the CCC Plus Waiver and PDN services through the EPSDT benefit at the same time.

10. Congregate PDN.

a. If more than one waiver individual resides in the home, the same waiver provider shall be chosen to provide all PDN services for all waiver individuals in the home.

b. Only one nurse shall be authorized to care for no more than two waiver individuals in such arrangements. In instances when three waiver individuals

share a home, nursing ratios shall be determined by DMAS or its designated agent based on the needs of all the individuals who are living together. These congregate PDN hours shall be at the same scheduled shifts.

c. The unpaid primary caregiver shall be shared and shall be responsible for providing all care needs when a private duty nurse is not available.

12VAC30-120-925 Respite coverage in children's residential facilities

A. Individuals ~~with special needs who are enrolled in the EDCD Waiver and~~ who have a diagnosis of intellectual disability (ID) or developmental disability (DD) shall be eligible to receive respite services in children's residential facilities that are licensed for respite services for children with ID or DD.

B. These respite services shall be covered consistent with the requirements of 12VAC30-120-924, 12VAC30-120-930, and 12VAC30-120-935, whichever is in effect at the time of service delivery~~.~~ with the following exceptions:

1. An assessment by the nurse supervisor shall be conducted at the onset of each use of respite in the children's residential facility;

2. Documentation of each utilization of respite in a children's residential facility will document the arrival and departure times of the individual instead of the arrival and departure times of each staff member; and

3. The nurse supervisor shall review the utilization of respite services in the children's residential facility. The nurse supervisor shall not be required to conduct the supervisory visit in the home of the waiver individual.

12VAC30-120-927 Exception criteria for personal care services

DMAS shall apply the following criteria to individuals who request approval of personal care hours in excess of the maximum allowed 56 hours per week. In order to qualify for personal care hours in excess of 56 hours per week, the waiver individual shall:

1. Presently have a minimum level of care of B (the waiver individual has a composite activities of daily living (ADL) score between seven and 12 and has a medical nursing need) or C (the waiver individual has a composite ADL score of nine or higher and has a skilled medical nursing need).

2. In addition to meeting the requirements set out in subdivision 1 of this section, the individual shall have at least one of the following:

a. Documentation of dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and ~~eating/feeding~~ eating or feeding, as defined by the current ~~preadmission~~ LTSS screening criteria (12VAC30-60-303) (submitted to the service authorization contractor via DMAS-99);

b. Documentation of dependencies in both behavior and orientation as defined by the current ~~preadmission~~ LTSS screening criteria (12VAC30-60-303) (submitted to the service authorization contractor via DMAS-99); or

c. Documentation from the local department of social services that the individual has an open case (as described in subdivisions c (1) and c (2) of this subdivision 2) with either Adult Protective Services (APS) or Child Protective Services (CPS) and is therefore in need of additional services beyond the maximum allowed 56 hours per week. Documentation can be in the form of a phone log contact or any other documentation supplied (submitted to the service authorization contractor via attestation).

(1) For APS, an open case is defined as a substantiated APS case with a disposition of needs protective services and the adult accepts the needed services.

(2) For CPS, an open case is defined as being open to CPS investigation if it is both founded by the investigation and the completed family assessment documents the case with moderate or high risk.

12VAC30-120-930 General requirements for home and community-based participating providers

A. The following agency-directed services shall be provided through an agency that is either (i) licensed by VDH, (ii) certified by VDH under provisions of Title XVIII or Title XIX of the Social Security Act, or (iii) accredited either by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or by the Community Health Accreditation Program (CHAP) established by the National League of Nursing for Medicaid participation: personal care, respite care, PDN, skilled respite care, and congregate PDN. The provider shall make available verification of its license, certification, or accreditation upon request.

~~A.~~ B. Requests for participation shall be screened by DMAS or the designated DMAS contractor to determine whether the provider applicant meets the requirements for participation, as set ~~out~~ forth in the provider agreement, and demonstrates the abilities to perform, at a minimum, the following activities:

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal health care programs, including Medicaid (i.e., via the United States Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219, or email to providerexclusions@dmas.virginia.gov;

2. Immediately notify DMAS in writing of any change in the information that the provider previously submitted to DMAS;

3. ~~Except for waiver individuals who are subject to the DMAS Client Medical Management program Part VIII (12VAC30-130-800 et seq.) of 12VAC30-130 or are enrolled in a Medicaid managed care program~~ organization, ~~ensure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services are performed~~ Ensure freedom of choice to individuals seeking services from any institution, pharmacy, practitioner, or other provider qualified and enrolled in Medicaid at the time of delivery to perform the service required, except for waiver individuals who are subject to the DMAS Client Medical Management program as set out in Part VIII of 12VAC30 or are enrolled in a Medicaid managed care organization;

4. Ensure the individual's freedom to refuse medical care, treatment, and services;

5. Accept referrals for services only when staff is available to initiate and perform such services on an ongoing basis;

6. Provide services and supplies to individuals in full compliance with Title VI (42 USC § 2000d et seq.) of the Civil Rights Act of 1964 which prohibits discrimination

on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973 (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990 (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as are provided to the general public;

8. Submit charges to DMAS, the MCO, or the DMAS-designated service authorization contractor for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS payment methodology beginning with the individual's authorization date for the waiver services;

9. Use only DMAS-designated forms for service documentation except when otherwise permitted. The provider shall not alter the DMAS forms in any manner without prior written approval from DMAS;

10. Use DMAS-designated billing forms for submission of charges;

11. Perform no type of direct marketing activities to Medicaid individuals;

12. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

a. In all instances of forms required to be in records, all documents shall have original notes, dates, and signatures. Copied, re-dated, and photocopied forms, notes and signatures are prohibited. Signatures shall not be dated prior to the last date of rendered services for the appropriate form being used.

~~a.~~ b. In general, such records shall be retained for a period of at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for a period of at least six years after such minor has reached 18 years of age.

~~b.~~ c. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth;

13. Furnish information on the request of and in the form requested to DMAS, or its contractors, the Attorney General of Virginia or their authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement;

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

15. Pursuant to 42 CFR 431.300 et seq., § 32.1-325.3 of the Code of Virginia, and the Health Insurance Portability and Accountability Act (HIPAA), safeguard and hold confidential all information associated with an applicant or enrollee or individual that could disclose the ~~applicant's/enrollee's/individual's~~ identity of the applicant, enrollee, or individual. Access to information concerning the ~~applicant/enrollee/individual~~ applicant, enrollee, or individual shall be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency and any such access must be in accordance with the provisions found in 42 CFR 431.306 and 12VAC30-20-90;

16. When ownership of the provider changes, notify DMAS in writing at least 15 calendar days before the date of change;

17. Pursuant to §§ 63.2-100, 63.2-1509, and 63.2-1606 of the Code of Virginia, if a participating provider or the provider's staff knows or suspects that a home and community-based waiver services individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately ~~from first knowledge or suspicion of such knowledge~~ to the local department of social services adult or child protective services ~~worker~~ department as applicable or to the toll-free, 24-hour hotline as described on the local department of social services' website. Employers shall ensure and document that their staff is aware of this requirement;

a. The party having knowledge or suspicion of abuse, neglect, or exploitation shall also report this immediately to DMAS, or its authorized contractor separately as a critical incident. The provider shall ensure that in such instances of suspected or known abuse, neglect, and exploitation that DMAS, or its authorized contractor are informed after notifying adult or child protective services and will document the date and time of report.

b. If a participating provider or the provider’s staff knows or suspects that a waiver individual has incurred a critical incident that does not include suspected or known abuse, neglect, or exploitation, the party having knowledge or suspicion of the critical incident shall report this immediately to DMAS or the DMAS-designated contractor. Employers shall ensure and document that their staff is aware of this requirement and maintain copies of all records of reported critical incidents in the individual’s file.

18. In addition to compliance with the general conditions and requirements, adhere to the conditions of participation outlined in the ~~individual~~ provider's participation agreements, in the applicable DMAS provider manual, and in other DMAS laws, regulations, and policies. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures may result in a retraction of Medicaid payment or termination of the provider agreement, or both;

19. Meet minimum qualifications of staff.

a. For reasons of Medicaid individuals' safety and welfare, all employees shall have a satisfactory work record, as evidenced by at least two references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children. In instances of employees who have worked for only one employer, such employees shall be permitted to provide one appropriate employment reference and one appropriate personal reference including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children.

b. ~~Criminal record checks for both employees and volunteers conducted by the Virginia State Police. Proof that these checks were performed with satisfactory results shall be available for review by DMAS staff or its designated agent who are authorized by the agency to review these files. DMAS shall not reimburse the provider for any services provided by an employee or volunteer who has been convicted of committing a barrier crime as defined in § 32.1-162.9:1 of the Code of Virginia. Providers shall be responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. Provider staff shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the criminal record check confirms the provider's staff person or volunteer was convicted of a barrier crime.~~ Pursuant to 42 CFR 441.302 and 42 CFR 441.352, within 30 calendar days of employment, the staff or volunteer shall obtain an original criminal record clearance with respect to convictions for offenses specified in § 19.2-392.02 of the Code of Virginia or an original criminal history record from the Central Criminal Records Exchange.

(1) DMAS shall not reimburse a provider for services provided by a staff member or volunteer who works in a position that involves direct contact with a waiver individual until an original criminal record clearance or original criminal history record has been received. DMAS shall reimburse services provided by such staff member or volunteer during only the first 30 calendar days of employment if the provider can produce documented evidence that such person worked only under the direct supervision of another staff member or volunteer for whom a background check was completed in accordance with the requirements of this section. If an original criminal record clearance or original criminal history record is not received within the first 30 calendar days of employment, DMAS shall not reimburse the provider for services provided by such employee on the 31st calendar day through the date on which the provider receives an original criminal record clearance or an original criminal history record.

(2) DMAS shall not reimburse a provider for services provided by a staff member or volunteer who has been convicted of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02 of the Code of Virginia unless all of the following conditions are met: (i) the offense was punishable as a misdemeanor; (ii) the staff member or volunteer has been convicted of only one such offense; (iii) the offense did not involve abuse or neglect; and (iv) at least five years have elapsed since the conviction.

c. The staff or volunteer shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside of the Commonwealth.

d. Provider staff and volunteers shall not be debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at

https://oig.hhs.gov

~~c.~~ e. Provider staff and volunteers who serve waiver individuals who are minor children shall ~~also~~ be screened through the VDSS Child Protective Services (CPS) Central Registry. Provider staff and volunteers shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the VDSS CPS Central Registry check confirms the provider's staff person or volunteer has a finding.

20. Providers shall comply with requirements for person-centered planning and home and community based settings as described in 42 CFR 441.301. As part of

the person-centered planning process, providers shall discuss the available services to the individual to meet the individual's needs and shall not perform services that are not identified or agreed upon in the person-centered plan.

~~B.~~ C. DMAS shall terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories shall within 30 days of such conviction notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations, subject to applicable appeal rights, shall conform to § 32.1-325 D and E of the Code of Virginia and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

~~C.~~ D. ~~For DMAS to approve provider agreements with home~~ Home and community-based waiver services providers~~,~~ shall meet the following standards ~~shall be met~~:

1. Staffing, financial solvency, disclosure of ownership, and ensuring comparability of services requirements as specified in the applicable provider manual;

2. The ability to document and to maintain waiver individuals' case records in accordance with state and federal requirements;

3. Compliance with all applicable laws, regulations, and policies pertaining to ~~EDCD~~ CCC Plus Waiver services.

~~D.~~ E. The waiver individual shall have the option of selecting ~~the~~ a Medicaid-enrolled provider ~~of his choice from among those providers who are approved and who~~ that can appropriately meet ~~his~~ the individual's needs.

~~E.~~ F. A participating provider may voluntarily terminate ~~his~~ its participation in Medicaid by providing 30 days' written notification to DMAS.

~~F.~~ G. Except as otherwise provided by state or federal law, DMAS may terminate at will a provider's participation agreement on 30 days' written notice as specified in the DMAS participation agreement. DMAS may immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the Medicaid program. Such action precludes further payment by DMAS for services provided to individuals on or after the date specified in the termination notice.

~~G.~~ H. The provider or the managed care organizaation shall be responsible for completing the DMAS-225 form. ~~The provider shall~~ to notify the designated ~~Srv Auth~~ service authorization contractor~~, as appropriate,~~ and the local department of social services~~, in writing,~~ when any of the following events occur. ~~Furthermore, it shall be the responsibility of the designated Srv Auth contractor to also update DMAS, as requested, when any of the following events occur:~~

1. Home and community-based waiver services are ~~implemented~~ started;

2. A waiver individual dies;

3. A waiver individual is discharged from the provider's ~~EDCD~~ CCC Plus Waiver services;

4. Any other events (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 consecutive calendar days; or

5. ~~The initial selection by the waiver individual or family/caregiver of a provider to provide services, or a change by the waiver individual or family/caregiver of a provider, if it affects the individual's patient pay amount.~~ Changes in the individual's status that may affect the individual's patient pay amount or financial Medicaid eligibility.

~~H.~~ I. Changes or termination of services.

1. The provider may decrease the amount of authorized care if the revised POC is appropriate and based on the medical needs of the waiver individual. The participating provider shall collaborate with the waiver individual or the ~~family/caregiver/EOR~~ family, caregiver, or EOR, ~~or both~~ as appropriate, to develop the new POC and calculate the new hours of service delivery. The provider shall discuss the decrease in care with the waiver individual ~~or family/caregiver/EOR,~~ family, caregiver, or EOR, document the conversation in the waiver individual's record, and notify the designated ~~Srv Auth~~ service authorization contractor. The ~~Srv Auth~~ service authorization contractor shall process the decrease request and the waiver individual shall be notified of the change by letter. This letter shall clearly state the waiver individual's right to appeal this change.

2. If a change in the waiver individual's condition necessitates an increase in care, the participating provider shall assess the need for the increase and~~,~~ collaborate with the waiver individual and ~~family/caregiver/EOR,~~ family, caregiver, EOR, and MCO care coordinator as appropriate, to develop a POC for services to meet the changed needs. The provider may implement the increase in ~~personal/respite~~ personal care hours ~~without~~ prior to approval from DMAS, or the designated ~~Srv Auth~~ service authorization contractor, if the amount of services does not exceed the total amount established by DMAS as the maximum for the level of care designated for that individual on the plan of care.

3. Any increase to a waiver individual's POC that exceeds the number of hours allowed for that individual's level of care or any change in the waiver individual's level of care shall be authorized by DMAS or the designated ~~Srv Auth~~ service authorization contractor prior to the increase and be accompanied by adequate documentation justifying the increase.

4. In an emergency situation when either the health, safety, or welfare of the waiver individual or provider personnel is endangered, or both, the provider shall notify DMAS, or the designated ~~Srv Auth contractor,~~ service authorization contractor ~~shall be notified~~ in writing prior to discontinuing services. The provider shall give written notification to the waiver individual discontinuing services. ~~The~~ An advance written notification period ~~set out below~~ shall not be required. If appropriate, local department of social services adult or child protective services~~, as may be appropriate,~~ shall be notified immediately. ~~Appeal rights shall be afforded to the waiver individual.~~

5. In a nonemergency situation, when neither the health, safety, nor welfare of the waiver individual or provider personnel is endangered, the participating provider shall give the waiver individual at least 10 calendar days' written notification (plus three days for mail transit for a total of 13 calendar days from the letter's date) of the intent to discontinue services. The notification letter shall provide the reasons for and the effective date the provider will be discontinuing services. ~~Appeal rights shall be afforded to the waiver individual.~~

~~I.~~ J. Staff education and training requirements.

1. RNs shall (i) be currently licensed to practice in the Commonwealth as an RN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or ~~NF~~ nursing facility, specialized care nursing facility, or long-stay hospital or as an LPN who worked for at least one year in one of these settings; and (iii) ~~submit to a criminal records check~~ meet the requirements of subdivision A 19 of this section regarding criminal record checks and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The RN shall not be compensated for services provided to the waiver individual if this record check verifies that the RN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the RN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

2. LPNs shall work under supervision as set out in ~~18VAC90-20-37~~ 18VAC90-19-70. LPNs shall (i) be currently licensed to practice in the Commonwealth as an LPN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) shall have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, ~~or~~ NF, specialized care NF, or long-stay hospital. The LPN shall meet the qualifications and skills, prior to being assigned to care for the waiver individual, that are required by the individual's POC; and (iii) ~~submit to a criminal records check~~ meet the requirements of subdivision A 19 of this section regarding criminal record checks and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The LPN shall not be compensated for services provided to the waiver individual if this record check verifies that the LPN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the LPN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

3. All RNs and LPNs who provide PDN services shall have either (i) at least six months of related clinical experience as documented in their work history, which may include work in acute care hospitals, long-stay hospitals, rehabilitation hospitals, or specialized care nursing facilities or (ii) completed a provider training program related to the care and technology needs of the assigned waiver individual.

a. Training programs established by providers shall include, at a minimum, the following:

(1) Trainers (either RNs or respiratory therapists) shall have at least six months hands-on successful experience in the areas in which the trainer provides training, such as ventilators, tracheostomies, peg tubes, and nasogastric tubes.

(2) Training shall include classroom time as well as direct hands-on demonstration of mastery by the trainee of the specialized skills required to work with individuals who have technology dependencies.

(3) The training program shall include the following subject areas as they relate to the care to be provided by the nurse: (i) human anatomy and physiology, (ii) medications frequently used by technology dependent individuals, (iii) emergency management, and (iv) the operation of the relevant equipment.

(4) Providers shall assure the nurses' competency and mastery of the skills necessary to care successfully for a waiver individual prior to assignment.

Documentation of successful completion of such training course and mastery of the specialized skills required to work with individuals who have technology dependencies shall be maintained in the provider's personnel records. This documentation shall be provided to DMAS upon request.

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

~~3.~~ 4. Personal care aides who are employed by personal care agencies that are licensed by VDH shall meet the requirements of 12VAC5-381. In addition, personal care aides shall also receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services.

~~4.~~ 5. Personal care aides who are employed by personal care agencies that are not licensed by the VDH shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities, as ensured by the provider prior to being assigned to the care of an individual, and shall have the required skills and training to perform the services as specified in the waiver individual's POC and related supporting documentation.

a. Personal care aides' required initial (that is, at the onset of employment) training~~, as further detailed in the applicable provider manual,~~ shall be met in one of the following ways: (i) registration with the Board of Nursing as a certified nurse aide; (ii) graduation from an approved educational curriculum as listed by the Board of Nursing; or (iii) completion of the provider's educational curriculum, which must be a minimum of 40 hours in duration, as taught by an RN who meets the same requirements as the RN listed in subdivision 1 of this subsection.

b. In addition, personal care aides shall also be required to receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services, which shall be documented in the aide’s record.

~~5.~~ 6. Personal care aides shall:

a. Be at least 18 years of age or older;

b. Be able to read and write English to the degree necessary to perform the expected tasks and create and maintain the required documentation;

c. Be physically able to perform the required tasks and have the required skills to perform services as specified in the waiver individual's supporting documentation;

d. Have a valid social security number that has been issued to the personal care aide by the Social Security Administration;

e. ~~Submit to a criminal records check~~ Meet the requirements of subdivision A 19 of this section regarding criminal record checks and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. ~~The aide shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the aide has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the aide has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;~~

f. Understand and agree to comply with the DMAS ~~EDCD~~ CCC Plus Waiver requirements; and

g. Receive tuberculosis (TB) screening as specified in the criteria used by ~~the~~ VDH.

~~6.~~ 7. Consumer-directed personal care attendants shall:

a. Be 18 years of age or older;

b. Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required documentation;

c. Be physically able to perform the required tasks and have the required skills to perform consumer-directed services as specified in the waiver individual's supporting documentation;

d. Have a valid social security number that has been issued to the personal care attendant by the Social Security Administration;

e. ~~Submit to a criminal records check~~ Meet the requirements of subdivision A 19 of this section and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. ~~The attendant shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the attendant has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the attendant has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;~~

f. Understand and agree to comply with the DMAS ~~EDCD~~ CCC Plus Waiver requirements;

g. Receive tuberculosis (TB) screening as specified in the criteria used by the VDH; and

h. Be willing to attend training at the ~~individual's or family/caregiver's~~ request of the individual, family, caregiver, or EOR.

12VAC30-120-935 Participation standards for specific covered services

A. The personal care providers, respite care providers, ADHC providers, private duty nursing providers, and ~~CD~~ services facilitators shall develop an individualized POC that addresses the waiver individual's service needs. Such plan shall be developed in collaboration with the waiver individual or the individual's ~~family/caregiver/EOR,~~ family, caregiver, or EOR, as appropriate.

B. DMAS shall not reimburse for any waiver services rendered to waiver individuals when either (i) the spouse of the waiver individual or (ii) the parent (natural, adoptive, step, or foster parent) or other legal guardian of the minor child waiver individual is the one providing the service.

1. Payment shall not be made for personal care or respite services furnished by other family members living under the same roof as the waiver individual unless there is objective written documentation as to why no other person or provider is available to render the service. The nurse supervisor or services facilitator shall initially make the determination and document it fully in the individual’s record.

2. Payment shall not be made for AT, EM, transition services, or services facilitation services furnished by other family members living under the same roof as the waiver individual receiving services.

3. Payment shall not be made for PDN services furnished by other family members, legal guardians of the waiver individual, or other persons living under the same roof as the waiver individual receiving the service.

4. Family members who are approved to be reimbursed for providing personal care or respite care services shall meet the same qualifications as all other personal care aides or CD attendants.

5. Payment shall not be made for respite care services if the primary caregiver, as identified in the records, receives payment for providing personal care services to the individual. Providers shall document the primary caregiver and whether the caregiver is paid or unpaid in the individual's record prior to requesting respite care service authorization.

~~B.~~ C. Agency providers shall employ appropriately licensed professional staff who can provide the covered waiver services required by the waiver ~~individuals~~ individual. Providers shall require that the supervising ~~RN/LPN~~ RN or LPN be available by phone at all times that the ~~LPN/attendant~~ LPN ~~and~~ or aide ~~consumer-directed services facilitators, as appropriate, are~~ is providing services to the waiver individual.

D. Agency staff (RNs, LPNs, or aides) or CD attendants shall only be reimbursed by DMAS for services if they are physically present with the waiver individual and are awake to perform the services outlined in the individual's plan of care.

~~C. Agency staff (RN, LPNs, or aides) or CD attendants shall not be reimbursed by DMAS for services rendered to waiver individuals when the agency staff or the CD attendant is either (i) the spouse of the waiver individual; or (ii) the parent (biological, adoptive, legal guardian) or other legal guardian of the minor child waiver individual.~~

~~1. Payment shall not be made for services furnished by other family members living under the same roof as the individual enrolled in the waiver receiving services unless there is objective written documentation completed by the consumer-directed services facilitator as to why no other provider is available to render the personal services. The consumer-directed services facilitator shall initially make this determination and document it fully in the individual's record.~~

~~2. Family members who are approved to be reimbursed for providing personal services shall meet the same qualifications as all other CD attendants.~~

E. A single agency-directed aide, consumer-directed attendant, RN, or LPN who provides personal care or respite services shall be reimbursed at a maximum limit of 16 hours per day for services rendered to an individual in order to ensure the health and safety of the individual receiving these services.

~~D.~~ F. Failure to provide the required services, conduct the required reviews, and meet the documentation standards as stated in this section ~~may~~ shall result in ~~DMAS charging~~ audited providers ~~with~~ returning overpayments ~~and requiring the return of the overpaid funds~~ to DMAS.

~~E.~~ G. In addition to meeting the general conditions and requirements, home and community-based services participating providers shall also meet the following requirements:

1. ADHC services provider. In order to provide ~~these~~ HCBS services, ~~the adult day care center (ADCC)~~ adult day health center (ADHC) shall:

a. Hold a license with VDSS for adult day care center (ADCC) and ~~Make~~ make available a copy of the current VDSS license for DMAS review and verification ~~purposes~~ prior to the provider applicant's enrollment as a Medicaid provider;

b. ~~Adhere to the ADCC standards of VDSS as defined in 22VAC40-60 including provision of activities for waiver individuals;~~ Meet and maintain compliance with provisions of HCBS rules as detailed in the provider agreement and as described in 42 CFR 441.301; and

c. Employ the following:

(1) A director who shall be responsible for overall management of the center's programs and employees pursuant to 22VAC40-60-320. The director shall be the ~~provider~~ provider's contact person for DMAS and the designated ~~Srv Auth~~ service authorization contractor and shall be responsible for responding to communication from DMAS and the designated ~~Srv Auth~~ service authorization contractor. The director shall be responsible for ensuring the development of the POCs for waiver individuals. The director shall assign ~~either himself, the activities director if there is one, RN, or therapist~~ a staff member to act as the ~~care~~ ADHC coordinator for each waiver individual and shall document ~~in the individual's medical record~~ the identity of the ~~care~~ ADHC coordinator in each individual's record. The ADHC coordinator can be the director, the activities director, RN, or therapist. The ~~care~~ ADHC coordinator shall be responsible for management of the waiver individual's POC and for its review with the program aides and any other staff, as necessary.

(2) A RN who shall be responsible for administering to and monitoring the health needs of waiver individuals. The RN may also contract with the center. The RN shall be responsible for the planning and implementation of the POC involving multiple services where specialized health care knowledge may be needed. The RN shall be present a minimum of eight hours each month at the center. DMAS may require the RN's presence at the center for more than this minimum standard depending on the number of waiver individuals who are in attendance and according to the medical and nursing needs of the waiver individuals who attend the center. Although DMAS does not require that the RN be a full-time staff position, there shall be a RN available, either in person or by telephone, to the center's waiver individuals and staff during all times that the center is in operation. The RN shall be responsible for:

(a) Providing periodic evaluation~~, at least every 90 days,~~ of the nursing needs of each waiver individual at least every 90 days or sooner when there is a change in the individual's ADHC level of care needs;

(b) Providing the nursing care and treatment as documented in the waiver individual's POC; and

(c) Monitoring, recording, and administering of prescribed medications or supervising the waiver individual in self-administered medication.

(3) Personal care aides who shall be responsible for overall care of waiver individuals such as assistance with ADLs, ~~social/recreational~~ social or recreational activities, and other health and therapeutic-related activities. Each program aide hired by the provider shall be screened to ensure compliance with training and skill mastery qualifications required by DMAS. The aide shall, at a minimum, have the following qualifications:

(a) Be 18 years of age or older;

(b) Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required waiver individual documentation of services rendered;

(c) Be physically able to perform the work and have the skills required to perform the tasks required in the waiver individual's POC;

(d) Have a valid social security number issued to the program aide by the Social Security Administration;

(e) Have satisfactorily completed an educational curriculum as set out in ~~clauses (i), (ii), and (iii) of~~ this subdivision ~~E 1 c 3 (e)~~. Documentation of successful completion shall be maintained in the aide's personnel file and be available for review by DMAS staff. Prior to assigning a program aide to a waiver individual, the center shall ensure that the aide has either (i) registered with the Board of Nursing as a certified nurse aide; (ii) graduated from an approved educational curriculum as listed by the Board of Nursing; or (iii) completed the provider's educational curriculum, at least 40 hours in duration, as taught by an RN who is licensed in the Commonwealth or who holds a multi-state licensing privilege.

(4) An Activities Director who shall be responsible for directing recreational and social activities for the ADHC recipients. The director, at a minimum, shall have the following qualifications:

(a) A minimum of 48 semester hours or 72 quarter hours of post-secondary education from an accredited college or university with a degree in recreational therapy, occupational therapy, or a related field such as art, music, or physical education, and

(b) Have one year of related experience, which may include work in an acute care hospital, rehabilitation hospital, or nursing home, or have completed a course of study including the prescribed internship in occupation, physical, or recreational therapy or music, dance, art therapy, or physical education.

~~(4)~~ (5) The ADHC coordinator who shall coordinate, pursuant to 22VAC40-60-695, the delivery of the activities and services as prescribed in the waiver individual's POC and keep such plans updated, record 30-day progress notes concerning each waiver individual, and review the waiver individual's daily records each week. If a waiver individual's condition changes more frequently, more frequent reviews and recording of progress notes shall be required to reflect the individual's changing condition. Copied or re-dated notes are not acceptable.

~~2.~~ d. Recreation and social activities responsibilities. The center shall provide planned recreational and social activities suited to the waiver individual's needs and interests and designed to encourage physical exercise, prevent deterioration of each waiver individual's condition, and stimulate social interaction.

e. The ADHC shall allow the care coordinator, DMAS, or the managed care organization to meet with waiver individuals to complete the annual individual experience survey, as required in the provisions of 42 CFR 441.301.

~~3.~~ f. The center shall maintain all records of each Medicaid individual. These records shall be reviewed periodically by DMAS staff or its designated agent who is authorized by DMAS to review these files. At a minimum, these records shall contain~~, but shall not necessarily be limited to~~:

~~a.~~ (1) DMAS required forms as specified in the center's provider-appropriate guidance documents;

~~b.~~ (2) Interdisciplinary POCs developed, in collaboration with the waiver individual ~~or family/caregiver~~ , family, or caregiver, or both as may be appropriate, by the center's director, RN, and therapist, as may be appropriate, and any other relevant support persons;

~~c.~~ (3) Documentation of interdisciplinary staff meetings that shall be held at least every three months to reassess each waiver individual, ~~and~~ evaluate the adequacy of the POC, and make any necessary revisions;

~~d.~~ (4) At a minimum, 30-day goal-oriented progress notes recorded by the designated ADHC ~~care~~ coordinator. If a waiver individual's condition and treatment POC changes more often, progress notes shall be written more frequently than every 30 days (copied or re-dated notes are not acceptable);

~~e.~~ (5) The daily record of services provided shall contain the specific services delivered by center staff. The record shall also contain the arrival and departure times of the waiver individual and shall be signed weekly by either the director, activities director, RN, or therapist employed by the center. The record shall be completed on a daily basis, neither before nor after the date of services delivery. At least once a week, a staff member shall chart significant comments regarding care given to the waiver individual. If the staff member writing comments is different from the staff signing the weekly record, that staff member shall sign the weekly comments. A copy of this record shall be given weekly to the waiver individual ~~or family/caregiver~~ , family, or caregiver, and it shall also be maintained in the waiver ~~individual-specific~~ individual's medical record; and

~~f.~~ (6) All contacts shall be documented in the waiver individual's medical record, including correspondence made to and from the individual with ~~family/caregivers~~ family, caregivers, physicians, DMAS, the designated ~~Srv Auth~~ service authorization contractor, formal and informal services providers, and all other professionals related to the waiver individual's Medicaid services or medical care.

~~F.~~ 2. Agency-directed personal care services. The personal care provider agency shall hire or contract with and directly supervise a RN who provides ongoing supervision of all personal care aides and LPNs. LPNs may supervise, pursuant to their licenses, personal care aides based upon RN assessment of the waiver individual's health, safety, and welfare needs.

~~1.~~ a. The RN supervisor shall make an initial home assessment visit on or before the start of care for all individuals admitted to personal care, when a waiver individual is readmitted after being discharged from services, or if ~~he~~ the individual is transferred from another provider, ADHC, or ~~from a CD services program~~ other waiver service**.**

b. Within 30 days after the initial home assessment visit, the RN supervisor shall visit the individual and the individual's family or caregiver, as appropriate, to monitor the plan of care, to reassess the individual's needs, and to determine if the services rendered are adequate to ensure the health, safety, and welfare of the individual.

~~2.~~ c. During a home visit, the RN supervisor shall evaluate, at least every 90 days, the LPN supervisor's performance and the waiver individual's needs to ensure the LPN supervisor's abilities to function competently and shall provide training as

necessary. This shall be documented in the waiver individual's record. A reassessment of the individual's needs and review of the POC shall be performed and documented during these visits.

~~3.~~ d. The ~~RN/LPN~~ nurse supervisor shall also make supervisory visits based on the assessment and evaluation of the care needs of waiver individuals as often as needed and as defined in this subdivision to ensure both quality and appropriateness of services.

~~a.~~ (1) The personal care provider agency shall have the responsibility of determining when supervisory visits are appropriate for the waiver individual's health, safety, and welfare. Supervisory visits shall be at least every 90 days. This determination must be documented in the waiver individual's ~~records~~ record by the RN on the initial assessment and in the ongoing assessment records.

~~b.~~ (2) If DMAS determines that the waiver individual's health, safety, or welfare is in jeopardy, DMAS may require the provider's ~~RN or LPN~~ nurse supervisor to supervise the personal care aides more frequently than once every 90 days. These visits shall be conducted at this designated increased frequency until DMAS determines that the waiver individual's health, safety, or welfare is no longer in jeopardy. This shall be documented by the provider and entered into the individual's record.

~~c.~~ (3) During visits to the waiver individual's home, the ~~RN/LPN~~ nurse supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the individual's current functioning status, ~~and~~ medical needs, and social needs. ~~The personal care aide's record shall be reviewed and the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed.~~ The nurse supervisor shall review the record of the aide or LPN and discuss with the individual, family, or caregiver the satisfaction with the type and amount of services.

~~d.~~ (4) If the ~~supervising~~ ~~RN/LPN~~ nurse supervisor must be delayed in conducting the regular supervisory visit, such delay shall be documented in the waiver individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the waiver individual's first availability.

~~e.~~ (5) A ~~RN/LPN~~ nurse supervisor shall be available to the personal care aide for conferences pertaining to waiver individuals being served by the aide.

~~(1)~~ (a) The ~~RN/LPN~~ nurse supervisor shall be available to the aide by telephone at all times that the aide is providing services to waiver individuals.

~~(2)~~ (b) The ~~RN/LPN~~ nurse supervisor shall evaluate the personal care aide's performance and the waiver individual's needs to identify any insufficiencies in the personal care aide's abilities to function competently and shall provide training as indicated. This shall be documented in the waiver individual's record.

~~f.~~ (6) Licensed practical nurses (LPNs). As permitted by ~~his~~ the license, the LPN may supervise personal care aides. To ensure both quality and appropriateness of services, the LPN supervisor shall make supervisory visits of the aides as often as needed, but no fewer visits than provided in a waiver individual's POC as developed by the RN in collaboration with the individual and the individual's ~~family/caregivers~~ family or caregivers, or both, as appropriate.

~~(1)~~ (a) During visits to the waiver individual's home, a LPN-supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services, the individual's current functioning status, medical needs and social

needs. The personal care aide's record shall be reviewed and the waiver individual's ~~or family/caregiver's~~ , family's, or caregiver's, ~~or both,~~ satisfaction with the type and amount of services discussed.

~~(2)~~ (b) The LPN supervisor shall evaluate the personal care aide's performance and the waiver individual's needs to identify any insufficiencies in the aide's abilities to function competently and shall provide training as required to resolve the insufficiencies. This shall be documented in the waiver individual's record and reported to the RN supervisor.

~~(3)~~ (c) An LPN supervisor shall be available to personal care aides for conferences pertaining to waiver individuals being served by them.

~~g.~~ (7) Personal care aides. The agency provider may employ and the ~~RN/LPN~~ nurse supervisor shall directly supervise personal care aides who provide direct care to waiver individuals. Each aide hired to provide personal care shall be evaluated by the provider ~~agency~~ to ensure compliance with qualifications and skills required by DMAS pursuant to 12VAC30-120-930.

~~4. Payment shall not be made for services furnished by family members or caregivers who are living under the same roof as the waiver individual receiving services, unless there is objective written documentation as to why no other provider or aide is available to provide the care. The provider shall initially make this determination and document it fully in the waiver individual's record.~~

~~5.~~ e. Required documentation for a waiver individual's records. The provider shall maintain all records for each individual receiving personal care services. These records shall be separate from those of non-home and community-based ~~care~~ waiver services, such as companion or home health services. These records shall be reviewed periodically by DMAS or its designated agent. At a minimum, the record shall contain:

~~a.~~ (1) All personal care aides' records (DMAS-90) to include (i) the specific services delivered to the waiver individual by the aide; (ii) the personal care aide's actual daily arrival and departure times; (iii) the aide's weekly comments or observations about the waiver individual, including observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and (iv) any other information appropriate and relevant to the waiver individual's care and need for services.

~~b.~~ (2) The personal care aide's and individual's or responsible caregiver's signatures, including the date, shall be recorded on these records verifying that personal care services have been rendered during the week of the service delivery.

~~(1)~~ (a) An employee of the provider shall not sign for the waiver individual unless ~~he~~ that employee is a family member or unpaid caregiver of the waiver individual.

~~(2)~~ (b) Signatures, times, and dates shall not be placed on the personal care aide record earlier than the last day of the week in which services were provided ~~nor~~ no ~~later~~ more than seven calendar days from the date of the last service.

~~C.~~ 3. Agency-directed respite care services.

~~1.~~ a. To be approved as a respite care provider with DMAS, the respite care agency provider shall:

~~a.~~ (1) Employ or contract with and directly supervise either a RN or LPN, or both, who will provide ongoing supervision of all respite care ~~aides/LPNs~~ aides or LPNs, as appropriate. A RN shall provide supervision to all direct care and supervisory LPNs.

~~(1)~~ (a) When respite care services are received on a routine basis, the minimum acceptable frequency of the required ~~RN/LPN~~ nurse supervisor's visits shall not exceed every 90 days, based on the initial assessment. If a waiver individual is also receiving personal care or private duty nursing services, the respite care ~~RN/LPN~~ nurse supervisory visit may coincide with the personal care ~~RN/LPN~~ nurse supervisory visits. However, the ~~RN/LPN~~ nurse supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

~~(2)~~ (b) When respite care services are not received on a routine basis but are episodic in nature, a ~~RN/LPN~~ nurse supervisor shall conduct the home supervisory visit with the ~~aide/LPN~~ aide or LPN on or before the start of care. The ~~RN/LPN~~ RN or LPN shall review the utilization of respite services either every six months or upon the use of half of the approved respite hours, whichever comes first. If a waiver individual is also receiving personal care services from the same provider, the respite care ~~RN/LPN~~ nurse supervisory visit may coincide with the personal care ~~RN/LPN~~ nurse supervisory visit.

~~(3)~~ (c) During visits to the waiver individual's home, the ~~RN/LPN~~ nurse supervisor shall observe, evaluate, and document the adequacy and appropriateness of respite care services to the waiver individual's current functioning status, ~~and~~ medical needs, and social needs. ~~The aide's/LPN's record shall be reviewed along with the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed.~~ The nurse supervisor shall review the record of the aide or LPN and discuss with the individual, family, or caregiver the satisfaction with the type and amount of services.

~~(4)~~ (d) Should the required ~~RN/LPN~~ nurse supervisory visit be delayed, the reason for the delay shall be documented in the waiver individual's record. This visit shall be completed within 15 days of the waiver individual's first availability.

~~b.~~ (2) Employ or contract with aides to provide respite care services who shall meet the same education and training requirements as personal care aides.

~~c. Not hire respite care aides for DMAS reimbursement for services that are rendered to waiver individuals when the aide is either (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, legal guardian) or other guardian of the minor child waiver individual.~~

~~d.~~ (3) Employ ~~an~~ a LPN or RN to perform skilled respite care services when skilled respite services are offered. Such services shall be reimbursed by DMAS under the following circumstances:

~~(1)~~ (a) The waiver individual shall have a documented need for routine skilled respite care that cannot be provided by unlicensed personnel, such as an aide. These waiver individuals would typically require a skilled level of care involving, for example but not necessarily limited to, ventilators for assistance with breathing or either nasogastric or gastrostomy feedings;

~~(2)~~ (b) No other person in the waiver individual's support system is willing and able to supply the skilled component of the individual's care during the unpaid primary

caregiver's absence; and

~~(3)~~ (c) The waiver individual is unable to receive skilled nursing visits from any other source that could provide the skilled care usually given by the unpaid primary caregiver.

~~c.~~ (4) Document in the waiver individual's record the circumstances that require the provision of skilled respite services by an LPN or RN. At the time of the LPN's or RN's service, the LPN or RN shall also provide all of the skilled respite services normally provided by an aide.

~~2. Payment shall not be made for services furnished by other family members or caregivers who are living under the same roof as the waiver individual receiving services unless there is objective written documentation as to why no other provider or aide is available to provide the care. The provider shall initially make this determination and document it fully in the waiver individual's record.~~

~~3.~~ b. Required documentation for a waiver individual's records. The provider shall maintain all records for each waiver individual receiving respite services. These records shall be ~~separate~~ clearly labeled and maintained separately from those of non-home and community-based ~~care~~ waiver services, such as companion or home health services. These records shall be reviewed periodically either by the DMAS staff or a contracted entity who is authorized by DMAS to review these ~~files~~ records. At a minimum these records shall contain:

~~a.~~ (1) Forms as specified in the DMAS guidance documents.

~~b.~~ (2) All respite care ~~LPN/aide~~ LPN, RN, or aide records shall contain:

~~(1)~~ (a) The specific services delivered to the waiver individual by the ~~LPN/aide~~ LPN, RN, or aide;

~~(2)~~ (b) The respite care ~~LPN's/aide's~~ LPN's, RN's, or aide's daily arrival and departure times;

~~(3)~~ (c) Comments or observations recorded weekly about the waiver individual. ~~LPN/aide~~ LPN, RN, or aide comments shall include observation of the waiver individual's physical, medical, and emotional condition, daily activities, the individual's response to services rendered, and documentation of vital signs if taken as part of the POC.

~~c.~~ (3) ~~All~~ Skilled respite care LPN or RN records ~~(DMAS-90A)~~ , which may be documented on the DMAS 90-A, shall be reviewed and signed by the supervising RN and shall contain:

~~(1)~~ (a) The signatures of the skilled respite care ~~LPN/aide's~~ LPN or RN and waiver individual's or responsible ~~family/caregiver's~~ family or caregiver ~~signatures~~, including the date, verifying that skilled respite care services have been rendered during the week of service delivery as documented in the record.

~~(2)~~ (b) An employee of the provider shall not sign for the waiver individual unless ~~he~~ the employee is a family member or unpaid caregiver of the waiver individual.

(3) (c) Signatures, times, and dates shall not be placed on the skilled respite care ~~LPN/aide~~ LPN or aide record earlier than the last day of the week in which services were provided. Nor shall signatures be placed on the respite care ~~LPN/aide~~ LPN or aide records later than seven calendar days from the date of the last service.

~~H.~~ 4. Consumer-directed (CD) services facilitation for personal care and respite services.

~~1.~~ a. Any services rendered by attendants prior to dates authorized by DMAS or the service authorization contractor shall not be eligible for Medicaid reimbursement and shall be the responsibility of the waiver individual.

~~2.~~ b. If the services facilitator is not an RN, then the services facilitator shall inform the primary health care provider for the individual ~~who is enrolled in the waiver~~ that services are being provided within 30 days from the start of such services and request consultation with the primary health care provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary health care provider. The documentation of this written permission to contact the primary health care provider shall be retained in the individual's medical record. All contacts with the primary health care provider shall be documented in the individual's medical record.

~~3.~~ c. The ~~consumer-directed~~ services facilitator, or any staff or volunteer of the services facilitator, whether employed or contracted by a DMAS enrolled services facilitator, shall meet the following qualifications:

~~a.~~ (1) To be enrolled as a Medicaid ~~consumer-directed~~ services facilitator and maintain provider status, the ~~consumer-directed~~ services facilitator shall have sufficient knowledge, skills, and abilities to perform the activities required of such providers. In addition, the ~~consumer-directed~~ services facilitator shall have the ability to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the services provided.

~~b.~~ (2) Effective January 11, 2016, all ~~consumer-directed~~ services facilitators shall:

~~(1)~~ (a) Have a satisfactory work record as evidenced by at least two references from prior job ~~experiences from any human services work; such references shall not include any~~ experience with no evidence of abuse, neglect, or exploitation of incapacitated or older adults ~~or persons with disabilities~~ or children~~;~~. In instances of employees who have worked for only one employer, such employees shall be permitted to provide one appropriate employment reference and one appropriate personal reference including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children.

~~(2) Submit to a criminal background check being conducted. The results of such check shall contain no record of conviction of barrier crimes as set forth in § 32.1-162.9:1 of the Code of Virginia. Proof that the criminal record check was conducted shall be maintained in the record of the services facilitator. In accordance with 12VAC30-80-130, DMAS shall not reimburse the provider for any services provided by a services facilitator who has been convicted of committing a barrier crime as set forth in § 32.1-162.9:1 of the Code of Virginia;~~

(b) Within 30 calendar days of employment, the services facilitator, staff or volunteer shall obtain an original criminal record clearance with respect to convictions for offenses specified in § 19.2-392.02 of the Code of Virginia or an original criminal history record from the Central Criminal Records Exchange. The staff or volunteer shall also submit to a screening through the VDSS Child Protective Services (CPS) Central Registry if serving a waiver individual who is a minor child. Provider staff and volunteers shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the VDSS CPS Central Registry check confirms the provider’s staff person or volunteer has a finding.

(i) DMAS shall not reimburse a provider for services provided by a staff or volunteer who works in a position that involves direct contact with a waiver individual until an original criminal record clearance or original criminal history record has been received. DMAS shall reimburse services provided by such a staff person during only the first 30 calendar days of employment if the provider can produce documented evidence that such person worked only under the direct supervision of another staff person for whom a background check was completed in accordance with the requirements of this section. If an original criminal record clearance or original criminal history record is not received within the first 30 calendar days of employment, DMAS shall not reimburse the provider for services provided by such staff or volunteer on the 31st calendar day through the date on which the provider receives an original criminal record clearance or an original criminal history record.

(ii) DMAS shall not reimburse a provider for services provided by a staff or volunteer who has been convicted of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02 of the Code of Virginia unless all of the following conditions are met: (i) the offense was punishable as a misdemeanor; (ii) the staff or volunteer has been convicted of only one such offense; (iii) the offense did not involve abuse or neglect; and (iv) at least five years have elapsed since the conviction.

~~(3) Submit to a search of the VDSS Child Protective Services Central Registry that results in no founded complaint; and~~

(c) The staff or volunteer shall provide the hiring entity with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside of the Commonwealth.

(d) Not be debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at ~~**http://oig.hhs.gov/exclusions/exclusions_list.asp**~~.

https://www.oig.hhs.gov

~~c. The services facilitator shall not be compensated for services provided to the individual enrolled in the waiver effective on the date in which the record check verifies that the services facilitator (i) has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia, (ii) has a founded complaint confirmed by the VDSS Child Protective Services Central Registry, or (iii) is found to be listed on LEIE.~~

~~d.~~ (3) Effective January 11, 2016, all ~~consumer-directed~~ services facilitators shall possess the required degree and experience, as follows:

~~(1)~~ (a) Prior to initial enrollment by ~~the department~~ DMAS as a ~~consumer-directed~~ services facilitator or being hired by a Medicaid-enrolled services facilitator provider, all new applicants shall possess, at a minimum, either (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or (ii) a bachelor's degree in a non-health or human services field and possess a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

~~(2)~~ (b) Persons who are ~~consumer-directed~~ services facilitators prior to January 11, 2016, shall not be required to meet the degree and experience requirements of subdivision 3 d (1) of this subsection unless required to submit a new application to be a ~~consumer-directed~~ services facilitator after January 11, 2016.

~~c.~~ (4) Effective April 10, 2016, all ~~consumer-directed~~ services facilitators shall complete required training and competency assessments. Satisfactory competency assessment results shall be kept in the service facilitator's record. ~~(1)~~ All new and existing ~~consumer-directed consumer directed~~ services facilitators shall complete the DMAS-approved ~~consumer-directed services facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being approved as a consumer-directed services facilitator or being reimbursed for working with waiver individuals. (2) Persons who are consumer-directed services facilitators prior to January 11, 2016, shall be required to complete the DMAS-approved consumer-directed~~ services facilitator training and pass the corresponding competency assessment with a score of at least 80% in order to begin and to continue being reimbursed for or working with waiver individuals for the purpose of ~~Medicaid~~ reimbursement for services through this waiver.

~~f. Failure to satisfy the competency assessment requirements and meet all other requirements shall result in a retraction of Medicaid payment or the termination of the provider agreement, or both.~~

~~g. Failure to satisfy the competency assessment requirements and meet all other requirements may also result in the termination of a CD services facilitator employed by or contracted with a Medicaid enrolled services facilitator provider.~~

~~h.~~ (5) As a component of the renewal of the Medicaid provider agreement, all ~~CD~~ services facilitators shall pass the competency assessment every five years and achieve a score of at least 80%.

~~i.~~ (6) The ~~consumer-directed~~ services facilitator shall have access to a computer with Internet access that meets the security standards of Subpart C of 45 CFR Part 164 for the electronic exchange of information. Electronic exchange of information shall include, for example, checking individual eligibility, submission of service authorizations, submission of information to the fiscal employer agent, and billing for services.

~~j.~~ (7) The ~~consumer-directed~~ services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the ~~consumer-directed~~ services facilitator's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

(a) Knowledge of: ~~(a)~~ (i)Types of functional limitations and health problems that may occur in ~~older adults or~~ individuals with disabilities or older adults, as well as strategies to reduce limitations and health problems; ~~(b)~~ (ii) Physical care that may be required by ~~older adults or~~ individuals with disabilities or older adults, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take; ~~(c)~~ (iii) Equipment and environmental modifications that may be required by ~~older adults or~~ individuals with disabilities or older adults that reduce the need for human help and improve safety; ~~(d)~~ (iv) Various long-term care program requirements, including ~~nursing facility~~ institutional and assisted living facility placement criteria, Medicaid waiver

services, and other federal, state, and local resources that provide personal care and respite services; ~~(c)~~ (v) ~~Elderly or Disabled with Consumer-Direction~~ CCC Plus Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible; ~~(f)~~ (vi) How to conduct assessments (including environmental, ~~psychosocial,~~ psycho-social, health, and functional factors) and their uses in services planning; (g) (vii) Interviewing techniques; ~~(h)~~ (viii) The individual's right to make decisions about, direct the provisions of, and control ~~his~~ one's own consumer-directed services, including hiring, training, managing, approving the ~~time sheets~~ work shift entries of, and firing of an ~~aide~~ attendant; ~~(i)~~ (ix) The principles of human behavior and interpersonal relationships; and ~~(j)~~ (x) General principles of record documentation.

~~(2)~~ (b) Skills in: ~~(a)~~ (i) Negotiating with individuals, ~~family/caregivers,~~ family, and caregivers, and service providers; ~~(b)~~ (ii) Assessing, supporting, observing, recording, and reporting behaviors; ~~(c)~~ (iii) Identifying, developing, or providing services to individuals ~~who are older adults or individuals~~ with disabilities or older adults; and ~~(d)~~ (iv) Identifying services within the established services system to meet the individual's needs.

~~(3)~~ (c) Abilities to: ~~(a)~~ (i) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual or hearing impairments; ~~(b)~~ (ii) Demonstrate a positive regard for individuals and their families; ~~(c)~~ (iii) Be persistent and remain objective; ~~(d)~~ (iv) Work independently, performing job position duties under general supervision; ~~(e)~~ (v) Communicate effectively orally and in writing; and ~~(f)~~ (vi) Develop a rapport and communicate with individuals from diverse cultural backgrounds.

(8). Failure to satisfy the competency assessment requirements and meet all other requirements shall result in a retraction of Medicaid payment or the termination of the provider agreement, or both.

~~4.~~ d. Initiation of services and service monitoring.

~~a.~~ (1) Upon entry into ~~For~~ consumer-directed ~~model of service~~ services, the ~~consumer-directed~~ services facilitator shall make an initial comprehensive home visit at the primary residence of the individual to collaborate with the individual or the individual's ~~family/caregiver~~ family or caregiver, as appropriate, to identify the individual's needs, assist in the development of the plan of care with the waiver individual and individual's ~~family/caregiver~~ family or caregiver, as appropriate, and provide EOR management training within seven days of the initial visit. The initial comprehensive home visit shall be conducted only once upon the individual's entry into consumer-directed services. ~~If the individual changes, either voluntarily or involuntarily, the consumer-directed services facilitator,~~ The individual shall receive one comprehensive visit per lifetime. If the individual changes service facilitators, the new ~~consumer-directed~~ services facilitator shall complete a reassessment visit in lieu of a comprehensive visit. The EOR management training shall be limited to one visit per EOR.

(2) Within 30 days after the initial comprehensive visit, the services facilitator shall visit the individual and the individual's family or caregiver, as appropriate, to monitor the plan of care, to reassess the individual's needs, and to determine if the services rendered are adequate to ensure the health, safety, and welfare of the individual. During this visit, the services facilitator, individual, EOR, and family or caregiver, as appropriate, shall agree to the frequency of routine visits, which shall be conducted at least every 90 days but no more frequently than every 30 days. The agreement shall be documented in the service facilitator's records.

~~b.~~ (3) ~~After the initial comprehensive~~ During the routine visit, the services facilitator shall continue to monitor the plan of care on an as-needed basis~~, but in no event less frequently than every 90 days for personal care,~~ and shall conduct face-to-face meetings with the individual and may include the EOR, ~~family/caregiver~~ family or caregiver. ~~The services facilitator shall review the utilization of consumer-directed respite services, either every six months or upon the use of half of the approved respite services hours, whichever comes first, and shall conduct a face-to-face meeting with the individual and may include the family/caregiver.~~ Such ~~monitoring reviews~~ visits shall be documented in the individual's medical record.

(4) When respite is the sole service provided, the services facilitator shall review the utilization of consumer-directed respite services, either every six months or upon the use of half of the approved respite services hours, whichever comes first, and shall conduct a face-to-face meeting with the individual and may include the family or caregiver, as appropriate. Such visits shall be documented in the individual's record.

(5) Every six months, the services facilitator shall conduct a face-to-face reassessment visit with the individual and EOR, family or caregiver, as appropriate. During the visit, the services facilitator shall review the individual's current functional and support status, review all services the individual receives, including the existing plan of care, discuss the individual's and EOR's satisfaction with services, update the plan of care as necessary, and submit new service authorization requests for personal care hours and other waiver services if necessary. The services facilitator shall not conduct a routine visit and reassessment visit during the same visit but shall submit reimbursement for only a reassessment visit.

~~c.~~ (6) During all visits with the individual, the services facilitator shall observe, evaluate, and consult with the ~~individual/EOR~~ individual or EOR and may include the ~~family/caregiver,~~ family or caregiver ~~and~~ to document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning, cognitive status, and medical and social needs.
The ~~consumer-directed~~ services facilitator's written summary of the visit shall include at a minimum:

~~(1)~~ (a) Discussion with the waiver individual ~~or family/caregiver/EOR,~~ , family, caregiver, or EOR, as appropriate, concerning whether the service is adequate to meet the waiver individual's needs;

~~(2)~~ (b) Any suspected abuse, neglect, or exploitation and to whom it was reported;

~~(3)~~ (c) Any special tasks performed by the consumer-directed attendant and the consumer-directed attendant's qualifications to perform these tasks;

~~(4)~~ (d) The individual's ~~or family/caregiver's/EOR's~~ , family's, caregiver's, or EOR's satisfaction with the service;

~~(5)~~ (e) Any hospitalization or change in medical condition, functioning, or cognitive status; ~~and~~

~~(6)~~ (f) The presence or absence of the ~~consumer-directed~~ attendant ~~in the home~~ during the ~~consumer-directed~~ services facilitator's visit~~.~~ and;

(g) The appropriateness of the EOR to fulfill the responsibilities of the role.

(7) The services facilitator shall provide follow-up management training to the individual or EOR, as appropriate, under the following circumstances:

(a) The training shall be requested by the individual or EOR. Training shall not be provided at the request of the services facilitator, family, caregiver, or attendant;

(b) The training shall be limited to the role and responsibilities of the EOR. Training shall not include duties that are to be performed by the attendant;

(c) The training shall be provided in a face-to-face visit;

(d) The services facilitator shall utilize the management training service to reimburse for tuberculosis screening, cardiopulmonary resuscitation training, and influenza immunization for the attendant at the request of the EOR. Requests for reimbursement shall be limited to the exact cost of the activity. Documentation of the cost and receipt of such activities shall be maintained in the individual's record.

~~5.~~ e. DMAS, its designated contractor, or the fiscal/employer agent shall request a criminal record check and a check of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child, in accordance with 12VAC30-120-930, pertaining to the consumer-directed attendant on behalf of the waiver individual and report findings of these records checks to the EOR.

6. f. The ~~consumer-directed~~ services facilitator shall review and verify copies of timesheets work shift entries ~~during the face-to-face visits~~ to ensure that the hours approved in the plan of care are being provided and are not exceeded. If discrepancies are identified, the ~~consumer-directed~~ services facilitator shall discuss these with the individual or EOR to resolve discrepancies and shall notify the fiscal/employer agent. The ~~consumer-directed~~ services facilitator shall also review the individual's plan of care to ensure that the individual's needs are being met. Failure to conduct such reviews and verifications of timesheets work shift entries and maintain the documentation of these reviews shall result in a recovery by DMAS of payments made in accordance with 12VAC30-80-130.

~~7.~~ g. The services facilitator shall maintain records of each individual ~~that he serves~~ served. At a minimum, these records shall contain:

~~a.~~ (1) Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

~~b.~~ (2) The personal care plan of care. Such plans shall be reviewed by the provider every 90 days, annually, and more often as needed, and modified as appropriate. The respite services plan of care shall be included in the record and shall be reviewed by the provider every six months or when half of the approved respite service hours have been used whichever comes first. For the annual review and in cases where either the personal care or respite care plan of care is modified, the plan of care shall be reviewed with the individual, the ~~family/caregiver~~ family or caregiver, and EOR, as appropriate;

~~c.~~ (3) The ~~consumer-directed~~ services facilitator's dated notes documenting any contacts with the individual ~~or family/caregiver/EOR~~ , family, caregiver, or EOR and visits to the individual (copied or re-dated notes are not acceptable);

~~d.~~ (4) All contacts, including correspondence, made to and from the individual, EOR, ~~family/caregiver,~~ family or caregiver, physicians, DMAS, the designated service authorization contractor, MCO, formal and informal services provider, and

all other professionals related to the individual's Medicaid services or medical care;

~~c.~~ (5) All employer management training provided to the individual or EOR to include, for example, (i) ~~the individual's or EOR's~~ receipt of training on ~~their~~ the individual's or EOR's responsibilities for the accuracy of the consumer-directed attendant's ~~timesheets~~ work shift entries and (ii) the availability of the Consumer-Directed ~~Waiver Services~~ Employer of Record Manual available at **~~www.dmas.virginia.gov~~**; http://dmas.virginia.gov

~~f.~~ (6) All documents signed by the individual or EOR, as appropriate, that acknowledge the responsibilities as the employer; and

~~g.~~ (7) The DMAS required forms as specified in the ~~agency's waiver-specific guidance document.~~ DMAS Commonwealth Coordinated Care Plus Waiver Manual. Failure to maintain all required documentation shall result in action by DMAS to recover payments made in accordance with 12VAC30-80-130. Repeated instances of failure to maintain documentation may result in cancellation of the Medicaid provider agreement.

~~8.~~ h. In instances when the individual is consistently unable either to hire or retain the employment of a personal care ~~consumer-directed~~ attendant to provide consumer-directed personal care or respite services such as, for example, a pattern of discrepancies with the ~~consumer-directed~~ attendant's ~~timesheets~~ work shift entries, the ~~consumer-directed~~ services facilitator shall make arrangements, after conferring with DMAS or the managed care organization, to have the needed services transferred to an agency-directed services provider of the individual's choice or discuss with the individual ~~or family/caregiver/EOR,~~ , family, caregiver, or EOR ~~or both,~~ other service options.

~~9.~~ i. Waiver individual, ~~family/caregiver~~ family or caregiver, and EOR responsibilities.

~~a.~~ (1) The individual shall be authorized for the consumer-directed model of service, and the EOR shall successfully complete EOR management training performed by the ~~consumer-directed~~ services facilitator before the individual or EOR shall be permitted to hire a consumer-directed attendant for Medicaid reimbursement. Any service that may be rendered by a consumer-directed attendant prior to authorization by Medicaid shall not be eligible for reimbursement by Medicaid. Individuals who are eligible for consumer-directed services shall have the capability to hire and train their own consumer-directed attendants and supervise the consumer-directed attendants' performances. In lieu of handling their consumer-directed attendants themselves, individuals may have a ~~family/caregiver~~ family or caregiver, or other designated person serve as the EOR on their behalf. The EOR shall be prohibited from also being the Medicaid-reimbursed consumer-directed attendant for respite or personal care or the services facilitator for the individual.

~~b.~~ (2) Individuals shall acknowledge that ~~they will not knowingly continue to accept~~ consumer-directed personal care services shall not continue when the service is no longer appropriate or necessary for ~~their~~ the individual's care needs and that the individual shall inform the services facilitator of ~~their~~ a change in care needs. If the consumer-directed model of services continue after services have been terminated by DMAS or the designated service authorization contractor, the individual shall be held liable for the consumer-directed attendant compensation.

~~c.~~ (3) Individuals shall notify the ~~consumer-directed~~ services facilitator of all hospitalizations or admissions, for example, any rehabilitation ~~facility~~ hospital, rehabilitation hospital unit, ~~or~~ nursing facility, specialized care nursing facility, or long-stay hospital as consumer-directed attendant services shall not be reimbursed during such admissions. Failure to do so may result in the individual being held liable for the consumer-directed employee compensation.

~~l.~~ 5. Personal emergency response systems. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-930, PERS providers must also meet the following qualifications and requirements:

~~1.~~ a. A PERS provider shall be~~, but not necessarily be limited to,~~ a personal care agency, a durable medical equipment provider, a licensed home health provider, or a PERS manufacturer. All such providers shall have the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring;

~~2.~~ b. The PERS provider shall provide an emergency response center with fully trained operators who are capable of (i) receiving signals for help from an individual's PERS equipment 24 hours a day, 365 or 366 days per year, as appropriate; (ii) determining whether an emergency exists; and (iii) notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help;

~~3.~~ c. A PERS provider shall comply with all applicable Virginia statutes, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed;

~~4.~~ d. The PERS provider shall have the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the waiver individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit and shall provide temporary equipment, as may be necessary for the waiver individual's health, safety, and welfare, while the original equipment is being repaired or replaced;

~~5.~~ e. The PERS provider shall install, consistent with the manufacturer's instructions, all PERS equipment into a waiver individual's functioning telephone line or system within seven days of the request of such installation unless there is appropriate documentation of why this timeframe cannot be met. The PERS provider shall furnish all supplies necessary to ensure that the system is installed and working properly. The PERS provider shall test the PERS device monthly, or more frequently if needed, to ensure that the device is fully operational;

~~6.~~ f. The PERS installation shall include local seize line circuitry, which guarantees that the unit shall have priority over the telephone connected to the console unit should the telephone be off the hook or in use when the unit is activated;

~~7.~~ g. A PERS provider shall maintain a data record for each waiver individual at no additional cost to DMAS or the waiver individual. The record shall document all of the following:

~~a.~~ (1) Delivery date and installation date of the PERS equipment;

~~b.~~ (2) Waiver ~~individual/caregiver~~ individual or caregiver signature verifying receipt of the PERS equipment;

~~c.~~ (3) Verification by a monthly test that the PERS device is operational ~~and the waiver individual is still using it monthly or more frequently as needed~~;

~~d.~~ (4) The ~~Waiver individual~~ waiver individual's contact information, to be updated annually or more frequently as needed, as provided by the individual or the individual's ~~caregiver/EOR~~ caregiver or EOR;

~~e.~~ (5) A case log documenting the waiver individual's utilization of the system, all contacts, and all communications with the individual, ~~caregiver/EOR~~ caregiver or EOR, and responders;

~~f.~~ (6) Documentation that the waiver individual is able to use the PERS equipment through return demonstration; and

~~g.~~ (7) Copies of all equipment checks performed on the PERS unit;

~~8.~~ h. The PERS provider shall have backup monitoring capacity in case the primary system cannot handle incoming emergency signals;

~~9.~~ i. The emergency response activator shall be capable of being activated either by breath, touch, or some other means and shall be usable by waiver individuals who are visually or hearing impaired or physically disabled. The emergency response communicator shall be capable of operating without external power during a power failure at the waiver individual's home for a minimum period of 24 hours. The emergency response console unit shall also be able to self-disconnect and redial the backup monitoring site without the waiver individual resetting the system in the event it cannot get its signal accepted at the response center;

~~10.~~ j. PERS providers shall be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to ensure that the monitoring agency and the monitoring agency's equipment meet the following requirements. The PERS provider shall be capable of simultaneously responding to multiple signals for help from the waiver individuals' PERS equipment. The PERS provider's equipment shall include the following:

~~a.~~ (1) A primary receiver and a backup receiver, which shall be independent and interchangeable;

~~b.~~ (2) A backup information retrieval system;

~~c.~~ (3) A clock printer, which shall print out the time and date of the emergency signal, the waiver individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

~~d.~~ (4) A backup power supply;

~~e.~~ (5) A separate telephone service;

~~f.~~ (6) A toll-free number to be used by the PERS equipment in order to contact the primary or backup response center; and

~~g.~~ (7) A telephone line monitor, which shall give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds;

~~11.~~ k. The PERS provider shall maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures;

~~12.~~ l. The PERS provider shall document and furnish within 30 days of the action taken, a written report for each emergency signal that results in action being taken on behalf of the waiver individual. This excludes test signals or activations made in error. This written report shall be furnished to (i) the personal care provider; (ii) the respite care provider; (iii) the ~~CD~~ services facilitation provider; (iv) in cases where the individual only receives ADHC services, to the ADCC provider; or (v) to the transition coordinator for the service in which the individual is enrolled; and

~~13.~~ m. The PERS provider shall obtain and keep on file a copy of the most recently completed DMAS-225 form. Until the PERS provider obtains a copy of the DMAS-225 form, the PERS provider shall clearly document efforts to obtain the completed DMAS-225 form from the personal care provider, respite care provider, ~~CD~~ services facilitation provider, or ADCC provider.

~~J.~~ 6. Assistive technology (AT) and environmental modification (EM) services. AT and EM shall be provided only to waiver individuals ~~who also participate in the MFP demonstration program~~ by providers who have current provider participation agreements with DMAS.

~~1.~~ a. AT shall be rendered by providers having a current provider participation agreement with DMAS as durable medical equipment and supply providers. An independent, professional consultation shall be obtained, as may be required, from qualified professionals who are knowledgeable of that item for each AT request prior to approval by either DMAS or the ~~Srv Auth~~ service authorization contractor and may include training on such AT by the qualified professional. Independent, professional consultants shall include~~, but shall not necessarily be limited to,~~ ~~speech/language~~ speech or language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Providers that supply AT for a waiver individual may not perform ~~assessment/consultation,~~ assessment or consultation, write specifications, or inspect the AT for that individual. ~~Providers of services shall not be (i) spouses of the waiver individual; or (ii) parents (biological, adoptive, foster, or legal guardian) of the waiver individual.~~ AT shall be delivered within 60 days from the start date of the authorization. The AT provider shall ensure that the AT functions properly.

~~2.~~ b. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-930, as appropriate, environmental modifications shall be provided in accordance with all applicable state or local building codes by contractors who have provider agreements with DMAS. ~~Providers of services shall not be (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, foster, or legal guardian) of the waiver individual who is a minor child.~~ Modifications shall be completed within a year of the start date of the authorization.

~~3.~~ c. Providers of AT and EM services shall not be permitted to recover equipment that has been provided to waiver individuals whenever the provider has been charged, by either DMAS or its designated service authorization agent, with overpayments and is therefore being required to return payments to DMAS.

d. Providers of AT and EM services shall maintain in each individual's record all supporting documentation of the costs and estimates of the service. Should there be a change in the cost of the service, the new cost and estimate documentation shall also be included along with justification of the change in cost.

~~K. Transition coordination. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.~~

~~L.~~ 7. Transition services. This service shall be provided consistent with ~~12VAC30-120-2000 and 12VAC30-120-2010~~ Part XX of 12VAC30-120.

8. Private duty nursing (PDN).

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

b. The provider shall operate from a business office; and

c. The provider shall employ (or subcontract with) and directly supervise an RN or an LPN. The LPN and RN shall be currently licensed to practice in the Commonwealth. Prior to providing PDN services, the RN or LPN shall have either (i) at least six months of related clinical nursing experience or (ii) completed a provider training program related to the care and technology needs of the waiver individual as described in 12VAC30-120-930 J 3. Regardless of whether a nurse has six months of experience or completes a provider training course, the provider agency shall be responsible for assuring all nurses who are assigned to an individual are competent in the care needs of that individual.

d. As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 days to ensure both quality and appropriateness of PDN to assess the individual's and the family's or caregiver's satisfaction with the services being provided, to review the medication and treatments, and to update and verify that the most current physician signed orders are in the home record.

(1) The waiver individual shall be present when the supervisory visits are made;

(2) At least every other visit shall be in the individual's primary residence;

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

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

e. When skilled respite services are routine in nature and offered in conjunction with personal care (PC) services for adults, the RN supervisory visit conducted for personal care may serve as the supervisory visit for respite services. However, the supervisor shall document supervision of skilled respite services separately. For this purpose, the same individual record can be used with a separate section clearly labeled for documentation of skilled respite services.

f. For DMAS-enrolled PDN providers that also provide PC services, the provider shall employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all personal care aides. The supervising RN shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, nursing facility, or specialized care nursing facility. In addition to meeting the general conditions and requirements for home and community-based waiver services participating

providers as specified in 12VAC30-120-930 and 12VAC30-120-935, the provision of PC services shall also comply with the requirements of 12VAC30-120-930.

g. The following documentation shall be maintained for every individual for whom DMAS-enrolled providers render these services:

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

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

(3) Progress notes reflecting the individual's status and, as appropriate, progress toward the identified goals in the POC (copied or re-dated notes are not acceptable);

(4) All related communication with the individual and the individual's representative, the DMAS designated agent for service authorization, consultants, DMAS, VDSS, formal and informal service providers, all required referrals, as appropriate, to Adult Protective Services or Child Protective Services and all other professionals concerning the individual;

(5) All service authorization decisions rendered by the DMAS staff or the DMAS-designated service authorization contractor;

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

(7) Notes of any verbal or non-verbal cues, motions, signals, or actions the individual makes to indicate distress or uses to call in case of an emergency. The individual, primary caregiver, or family, as appropriate, shall share this information with the RN or LPN at the onset of services. Documentation of these cues shall be kept in the individual’s record and shall be reviewed periodically to ensure the individual is still able to perform these cues.

12VAC30-120-945 Payment for covered services

A. DMAS shall not reimburse providers, either agency-directed or consumer-directed, for any staff training required by these waiver regulations or any other training that may be required.

B. All services provided in the ~~EDCD~~ CCC Plus Waiver shall be reimbursed at a rate established by DMAS in its agency fee schedule.

1. DMAS or its contractor shall reimburse a per diem fee for ADHC services that shall be considered as payment in full for all services rendered to that waiver individual as part of the individual's approved ADHC plan of care.

2. Personal care (agency and consumer-directed), respite (agency and consumer-directed), and PDN ~~Agency personal care/respite~~ care services shall be reimbursed on an hourly basis consistent with the agency's fee schedule. Effective July 1, 2021, a single consumer-directed attendant who provides personal care or

respite services shall be reimbursed at the regular rate for up to 40 hours per week for authorized services rendered and at one and a half times the regular rate for up to 16 hours per week beyond 40 hours. This shall not apply to consumer-directed attendants who are exempt from overtime requirements under 29 U.S.C. § 552.102 of the federal Fair Labor Standards Act, 29 U.S.C. § 201 et seq.

~~3. Consumer-directed personal care/respite care services shall be reimbursed on an hourly basis consistent with the agency's fee schedule.~~

~~4~~. 3. Transition services. The total costs of these transition services shall be limited to $5,000 per waiver individual per lifetime and shall be expended within nine months from the start date of authorization. Transition services shall be reimbursed at the actual cost of the item; no mark ups shall be permitted.

~~5.~~ 4. Reimbursement for assistive technology (AT) and environmental modification (EM) services shall be ~~limited to those waiver individuals who are also participating in the MFP demonstration program~~ as follows:

a. All AT services provided in the ~~EDCD~~ CCC Plus Waiver shall be reimbursed as a service limit of one and up to a per member annual maximum of $5,000 per calendar year regardless of waiver. ~~AT services in this waiver shall be reimbursed up to a per individual annual MFP enrollment period not to exceed 12 months.~~ These limits shall apply regardless of whether the waiver individual remains in this waiver or changes to another waiver program. AT services shall be reimbursed in a manner that is reasonable and customary not to exceed the provider's usual and customary charges to the general public. No markups shall be permitted.

b. All EM services provided in the ~~EDCD~~ CCC Plus Waiver shall be reimbursed ~~per individual annual MFP enrollment period not to exceed 12 months~~ as a service limit of one and up to a per member annual maximum of $5,000 per calendar year regardless of waiver. These limits shall apply regardless of whether the individual remains in this waiver or changes to another waiver program. All EM services shall be reimbursed at the actual cost of material and labor and no mark ups shall be permitted.

~~6. DMAS shall reimburse a monthly fee for transition coordination consistent with the agency's fee schedule.~~

~~7.~~ 5. PERS monthly fee payments shall be consistent with the agency's fee schedule.

C. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the American with Disabilities Act (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973 (29 USC § 794), or the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia).

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

3. DMAS payments for EM services shall not be duplicative in homes where multiple waiver individuals reside.

12VAC30-120-1700 ~~Definitions.~~ (Repealed.)

Part XVII

Home and Community-Based Services for Technology Assisted Individuals Waiver (Repealed)

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

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

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

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

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

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

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

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

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

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

~~"Assess" means to evaluate an applicant's or an individual's condition, including functional status, current medical status, psychosocial history, and environment. Information is collected from the applicant or individual, applicant's or individual's representative, family, and medical professionals, as well as the assessor's observation of the applicant or individual.~~

~~"Assessment" means one or more processes that are used to obtain information about an applicant, including his condition, personal goals and preferences, functional limitations, health status, financial status and other factors that are~~

relevant to the determination of eligibility for services and is required for the authorization of and provision of services, and forms the basis for the development of the plan of care.

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

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

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

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

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

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

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

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

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

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

"Cost-effective" means the anticipated annual cost to Medicaid for technology assisted waiver services shall be less than or equal to the anticipated annual institutional costs to Medicaid for individuals receiving care in hospitals or specialized care nursing facilities.

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

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

"DMAS" means the Department of Medical Assistance Services.

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

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

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

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

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

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

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

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

~~"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children younger than 21 years of age according to federal guidelines that prescribe preventive and treatment services for Medicaid-eligible children as set out in 12VAC30-50-130.~~

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

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

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

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

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

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

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

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

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

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

~~"License" means proof of official or legal permission issued by the government for an entity or person to perform an activity or service. In the absence of a license~~

that may be required by either statute or regulation, the entity or person shall be prohibited from performing the activity or service for reimbursement by DMAS.

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

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

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

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

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

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

"Money Follows the Person" or "MFP" means the demonstration program as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

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

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

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

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

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

"Personal care (PC) services" means a range of support services that includes assistance with ADLs/IADLs, access to the community, and self-administration of medication or other medical needs, and the monitoring of health status and

~~physical condition provided through the agency-directed model. Personal care services shall be provided by PCAs within the scope of their licenses or certifications, as appropriate.~~

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

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

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

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

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

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

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

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

~~"Service authorization" or "serv auth" means the DMAS approval of a requested medical service for reimbursement prior to the provision of the service. Service authorizations shall be performed by DMAS or its service authorization contractor.~~

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

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

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

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

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

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

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

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

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

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

~~"VDSS" means the Virginia Department of Social Services.~~

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

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

12VAC30-120-1705 ~~Waiver description and legal authority.~~ (Repealed.)

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

B. Technology assisted waiver services shall be covered only for Medicaid-eligible individuals who have been determined eligible for waiver services and who also require the level of care provided in either long-stay hospitals or specialized care nursing facilities as long as age appropriate criteria are met. These services shall be the critical service necessary to delay or avoid the individual's placement in an appropriate facility. These waiver services shall not be covered for Medicaid-eligible individuals who reside in, but not necessarily limited to, the following types of facilities: assisted living facilities, nursing facilities, rehabilitation hospitals, long-stay hospitals, skilled or intermediate care nursing facilities, Intermediate Care Facilities for the Intellectually Disabled, group homes licensed by DBHDS, general acute care hospitals, or adult foster care homes.

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

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

E. Payments for tech waiver services shall not be provided to any financial institution or entity located outside of the United States pursuant to the Social Security Act § 1902(a)(80). Payments for tech waiver services furnished in another state shall (i) be provided for an individual who meets the requirements of 42 CFR § 431.52 and (ii) be limited to the same number of skilled PDN hours approved for the individual's home-based skilled PDN.

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

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

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

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

12VAC30-120-1710 ~~Individual eligibility requirements; preadmission screening.~~ (Repealed.)

~~A. Individual eligibility requirements.~~

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

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

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

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

3. An applicant for technology assisted waiver shall meet specialized care nursing facility criteria, including both medical and functional needs, and also be dependent on waiver services to avoid or delay facility placement and meet all criteria for the age appropriate assessments in order to be eligible for the tech waiver. Applicants shall not be enrolled in the tech waiver unless skilled private duty nursing (PDN) hours are ordered by the physician. The number of skilled PDN hours shall be based on the total technology and nursing score on the Technology Assisted Waiver Pediatric Referral form, DMAS-109 (when individuals are younger than 21 years of age). The number of skilled PDN hours for adults shall be based on the Technology Assisted Waiver Adult Referral form (DMAS-108).

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

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

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

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

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

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

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

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

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

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

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

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

(1) Applicants depending on mechanical ventilators;

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

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

c. Individuals who are 21 years of age or older shall have the Technology Assisted Waiver Adult Referral form (DMAS-108) completed and must be determined to be dependent on a ventilator or must meet all eight specialized care criteria

~~(12VAC30-60-320) for complex tracheostomy care in order to qualify for waiver enrollment.~~

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

~~5. A PAS is considered valid for the following timeframes. The validity of a PAS applies to individuals who are screened, meet the criteria for long-term care services, but have not yet begun receiving services during the periods outlined in subdivisions 5 a through 5 f of this subsection.~~

~~a. Zero to 180 days. Screenings are valid and do not require revisions or a new screening.~~

~~b. 181 days to 12 months. Screening revisions are required; revisions may also be done if there is a significant change in an individual's medical or physical condition. Revisions should be entered into the ePAS system, per the Medicaid web portal instructions, resulting in a claim being generated for the screening revision. For the purposes of this subdivision, "Electronic preadmission screening" or "ePAS" means the automated system for use by all entities contracted by DMAS to perform preadmission screenings pursuant to § 32.1-330 of the Code of Virginia. DMAS will cover the cost of the PAS.~~

~~c. Over 12 months. A new screening is required and reimbursement is made by DMAS. New screenings must be entered into ePAS according to the Medicaid web portal instructions.~~

~~d. Break in services. When an individual starts and then stops services for a period of time exceeding 30 consecutive calendar days, the PAS team will need to complete a revised screening prior to service resumption if the individual has not received any Medicaid funded long-term care services during the break in service delivery. DMAS will cover the cost of the PAS.~~

~~e. In any other circumstances, including hospitalization, that cause services to cease or to be interrupted for more than 30 consecutive calendar days, the individuals shall be referred back to the local department of social services for redetermination of his Medicaid eligibility. The provider shall be responsible for notifying the local department of social services via the DMAS-225 form when there is an interruption of services for 30 consecutive calendar days or upon discharge from the provider's services.~~

~~f. If the individual has been receiving ongoing services either through a nursing facility or a home and community-based service program, the screening timeframes do not apply.~~

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

~~7. DMAS shall be the final determining body for enrollment in the tech waiver and the determination of the number of approved skilled PDN hours for which DMAS will pay. DMAS has the ultimate responsibility for authorization of waiver enrollment and Medicaid skilled PDN reimbursement for tech waiver services.~~

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

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

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

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

~~4. All waiver individuals shall have the right to:~~

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

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

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

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

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

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

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

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

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

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

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

12VAC30-120-1720 ~~Covered services; limits; changes to or termination of services.~~ (Repealed.)

~~A. Coverage statement.~~

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

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

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

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

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

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

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

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

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

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

~~c. Limits placed on the amount of PDN that will be approved for reimbursement shall be consistent with the individual's age-appropriate technology assisted waiver referral form (DMAS-108 or DMAS-109) and medical necessity. Except for a minor individual's care during his first 15 days following initial enrollment into this waiver, in no instances shall the individual's POC or ongoing multiple POCs result in coverage of more than 112 hours of skilled PDN per week (Sunday through Saturday). The maximum number of approved hours authorized per week for minor children shall be based on their total approved points documented on the Technology Assisted Waiver Pediatric Referral form (DMAS-109). The maximum skilled PDN hours authorized per week for adult individuals shall be based on their technology and medical necessity justification documented on the Technology Assisted Waiver Adult Referral form (DMAS-108).~~

~~(1) The number of skilled PDN hours for minor individuals shall be based on the total technology and nursing score on the Technology Assisted Waiver Pediatric Referral form (DMAS-109) and updated by the DMAS staff when changes occur and with annual waiver eligibility redetermination by DMAS.~~

~~(2) Once the minor individual's composite score (total score) is derived, a LOC is designated for the individual as a Level A, B, or C. This LOC designation determines the maximum number of hours per week of skilled PDN that DMAS may allocate for a pediatric individual. Any hours beyond the approved maximum for such individual's LOC shall be medically necessary and service authorized by DMAS. Any POC submitted without approval for hours beyond the approved maximum for any particular LOC will only be entered for the approved maximum for that LOC.~~

~~(3) The results of the scoring assessment determine the maximum amount of hours available and authorization shall occur as follows:~~

~~(a) 50 – 56 points = 70 hours per week.~~

~~(b) 57 – 79 points = 84 hours per week.~~

~~(c) 80 points or greater = 112 hours per week.~~

~~(4) For minor individuals, whether living separately or in a congregate setting, during the first 15 calendar days after such individuals' initial admission to the waiver, skilled PDN may be covered for up to 24-hours per day, if required and appropriate to assist the family in adjustment to the care associated with technology assistance. After these first 15 calendar days, skilled PDN shall be reimbursed up to the maximum allowable hours per week based on the individual's total technology and nursing scores and provided that the aggregate cost-effectiveness standard is not exceeded for the individual's care.~~

~~(5) When reimbursement is to be made for skilled PDN services to be provided in schools, the nurse shall be in the same room as the waiver individual for the hours of skilled PDN care billed. When an individual receives skilled PDN while attending school, the total skilled PDN hours shall not exceed the authorized number of hours under his nursing score category on the Technology Assisted Waiver Pediatric Referral form (DMAS-109).~~

~~(6) For adult individuals, whether living separately or in a congregate setting, skilled PDN shall be reimbursed up to a maximum of 112 hours per week (Sunday~~

~~through Saturday) per tech waiver individual living in the household based on the individual's technology and medical justification and provided that the aggregate cost-effectiveness standard is not exceeded for the individual's care.~~

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

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

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

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

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

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

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

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

~~(vi) Receives tracheostomy care at least daily;~~

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

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

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

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

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

~~e. Exclusions from DMAS' coverage of skilled PDN:~~

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

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

~~(3) Skilled PDN services may be ordered but shall not be provided simultaneously with PDN respite care or personal care services as described in this section.~~

~~(4) Parents (natural, adoptive, legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the~~

~~same roof with the individual shall not provide skilled PDN services for the purpose of Medicaid reimbursement for the waiver individual.~~

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

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

~~f. Congregate skilled PDN.~~

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

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

~~(3) The primary caregiver shall be shared and shall be responsible for providing all care needs when a private duty nurse is not available.~~

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

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

~~a. This service shall be provided by skilled nursing staff licensed to practice in the Commonwealth under the direct supervision of a licensed, certified, or accredited home health agency and with which DMAS has a provider agreement to provide skilled PDN.~~

~~b. Skilled private duty respite care services shall be comprised of both skilled and hands-on care of either a supportive or health-related nature and includes (i) all skilled nursing care as ordered on the physician-certified POC, (ii) assistance with ADLs and IADLs, (iii) administration of medications or other medical needs, and (iv) monitoring of the health status and physical condition of the individual or individuals.~~

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

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

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

3. Assistive technology (AT) services. Assistive technology, as defined in 12VAC30-120-1700, devices shall be portable and shall be authorized per calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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

f. AT exclusions.

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

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

(3) All equipment or supplies already covered by the State Plan shall not be purchased under the waiver as AT. Such examples include:

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

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

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

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

4. Environmental modifications services shall be covered as defined in 12VAC30-120-1700. Medicaid reimbursement shall not occur before service authorization of EM services is completed by DMAS or the DMAS-designated service authorization contractor. EM services shall entail limited physical adaptations to preexisting structures and shall not include new additions to an existing structure that simply increase the structure's square footage.

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

~~b. EM shall be available costing up to a maximum amount of $5,000 per calendar year regardless of waiver for individuals who are receiving skilled PDN services.~~

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

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

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

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

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

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

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

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

~~k. EM exclusions.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

~~d. PC exclusions.~~

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

~~(2) Regardless of the combination of skilled PDN and PC hours, the total combined number of hours that shall be reimbursed by DMAS in a week shall not exceed 112 hours.~~

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

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

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

~~a. Transition services shall be service authorized by DMAS or its designated service authorization contractor in order for reimbursement to occur.~~

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

~~C. Changes to services or termination of services.~~

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

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

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

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

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

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

4. In a nonemergency situation (i.e., when the health, safety, or welfare of the waiver individual or provider personnel is not endangered), the provider shall provide the individual and the individual's representative 14 calendar days' written notification (plus three days to allow for mail transmission) of the intent to discharge the individual from agency services. Written notification shall provide the reasons for and the effective date of the termination of services as well as the individual's appeal rights. A copy of the written notification shall also be forwarded to the DMAS staff within five business days of the date of the notification.

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

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

~~7. When a waiver individual, regardless of age, requires admission to an acute care hospital for 30 days or more, the individual shall be discharged from waiver services. When such hospitalization exceeds 30 days and upon hospital discharge, readmission to waiver services is required. Such readmission requires reassessment by the discharge team and a determination that the individual continues to meet Medicaid eligibility, level of care criteria and medical criteria on the DMAS-108 or DMAS-109 form, as appropriate. If these criteria are met, the individual shall be readmitted to waiver services. For adults, ages 21 years and older, the individual shall meet the criteria for specialized care admissions. For children, younger than 21 years of age, the individual shall meet the criteria for long-stay hospital admissions and the age appropriate criteria.~~

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

12VAC30-120-1730 ~~General requirements for participating providers.~~ (Repealed.)

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

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

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

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

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

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

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

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

~~5. Perform a criminal background check on all employees, including the business owner, who may have any contact or provide services to the waiver individual. Such record checks shall be performed by the Virginia State Police for the Commonwealth. When the Medicaid individual is a minor child, searches shall also be made of the Virginia CPS Central Registry.~~

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

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

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

~~a. Immediately report to DMAS any exclusion information identified.~~

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

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

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

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

~~ensure that all employees are aware of the requirements to immediately report such suspected abuse, neglect, or exploitation to APS, CPS or human rights, as appropriate.~~

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

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

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

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

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

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

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

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

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

~~18. Meet staffing, financial solvency, disclosure of ownership, assurance of comparability of services requirements, and other requirements as specified in the provider's written program participation agreement with DMAS.~~

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

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

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

~~22. Retain records of minors for at least six years after such minors have reached 21 years of age.~~

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

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

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

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

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

~~a. All RN and LPN employees shall have a satisfactory work record, as evidenced by at least two references from prior job experiences. In lieu of this requirement for personal care aides only, employees who have worked for only one employer shall be permitted to provide two personal references. Providers who are not able to obtain previous job references about personal care aides shall retain written documentation showing their good faith efforts to obtain such references in the new employee's work record.~~

~~b. Staff and agencies shall meet any certifications, licensure, or registration, as applicable and as required by applicable state law. Staff qualifications shall be documented and maintained for review by DMAS or its designated agent. All~~

~~additional provider requirements as may be required under a specific waiver service in this part shall also be met.~~

~~c. All RNs and LPNs providing skilled PDN services shall be currently licensed to practice nursing in the Commonwealth. The LPN shall be under the direct supervision of an RN.~~

~~d. All RNs and LPNs who provide skilled PDN services shall have either (i) at least six months of related clinical experience as documented in their history, which may include work in acute care hospitals, long-stay hospitals, rehabilitation hospitals, or specialized care nursing facilities, or (ii) completed a provider training program related to the care and technology needs of the assigned tech waiver individual.~~

~~e. Training programs established by providers shall include, at a minimum, the following:~~

~~(1) Trainers (either RNs or respiratory therapists) shall have at least six months hands-on experience in the areas in which they provide training, such as ventilators, tracheostomies, peg tubes, and nasogastric tubes.~~

~~(2) Training shall include classroom time as well as direct hands-on demonstration of mastery of the specialized skills required to work with individuals in the technology assisted waiver by the trainee.~~

~~(3) The training program shall include the following subject areas as they relate to the care to be provided by the tech waiver nurse: (i) human anatomy and physiology, (ii) medications frequently used by technology dependent individuals, (iii) emergency management, and (iv) the operation of the relevant equipment.~~

~~(4) Providers shall assure the competency and mastery of the skills necessary to care for tech waiver individuals by the nurses prior to assigning them to a tech waiver individual. Documentation of successful completion of such training course and mastery of the specialized skills required to work with individuals in the technology assisted waiver shall be maintained in the provider's personnel records. This documentation shall be provided to DMAS upon request.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12VAC30-120-1740 ~~Participation standards for provision of services.~~ (Repealed.)

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

following documentation shall be maintained for every individual for whom DMAS-enrolled providers render these services:

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

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

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

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

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

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

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

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

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

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

8. Provider's HIPAA release of information form;

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

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

11. Documentation of all inpatient hospital or specialized care nursing facility admissions to include service interruption dates, the reason for the hospital or

specialized care nursing facility admission, the name of the facility or facilities and primary caregiver notification when applicable including all communication to DMAS;

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

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

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

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

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

2. Demonstrate a prior successful health care delivery;

3. Operate from a business office; and

4. Employ (or subcontract with) and directly supervise an RN or an LPN. The LPN and RN shall be currently licensed to practice in the Commonwealth. Prior to assignment to a tech waiver individual, the RN or LPN shall have either (i) at least six months of related clinical nursing experience or (ii) completed a provider training program related to the care and technology needs of the tech waiver individual as described in 12VAC30-120-1730 A 27 e. Regardless of whether a nurse has six months of experience or completes a provider training course, the provider agency shall be responsible for assuring all nurses who are assigned to an individual are competent in the care needs of that individual.

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

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

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

c. When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay shall be documented in the individual's

~~record, and the visit shall occur as soon as the individual is available. Failure to meet this standard may result in DMAS' recovery of payments made.~~

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

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

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

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

~~a. For DMAS-enrolled skilled PDN providers that also provide PC services, the provider shall employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all PCAs. The supervising RN shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility.~~

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

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

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

~~C. Assistive technology and environmental modification.~~

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

~~2. AT and EM shall be covered in the least expensive, most cost-effective manner. The provider shall document and justify why more cost-effective solutions cannot be used. DMAS and the DMAS-designated service authorization contractor may~~

~~request further documentation on the alternative cost-effective solutions as necessary.~~

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

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

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

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

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

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

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

~~g. Any additional cost estimates requested by DMAS.~~

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

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

12VAC30-120-1750 ~~Payment for services.~~ (Repealed.)

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

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

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

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

C. Duplication of services.

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

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

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

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

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

~~A. DMAS shall perform quality management reviews for the purpose of ensuring high quality of service delivery consistent with the attending physicians' orders, approved POCs, and service authorized services for the waiver individuals. Providers identified as not rendering reimbursed services consistent with such orders, POCs, and service authorizations shall be required to submit corrective action plans (CAPs) to DMAS for approval. Once approved, such CAPs shall be implemented to resolve the cited deficiencies.~~

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

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

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

12VAC30-120-1770 ~~Appeals; provider and recipient.~~ (Repealed.)

A. Providers shall have the right to appeal actions taken by DMAS. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia)

and DMAS regulations at 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

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

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