12VAC 30-120-215. Individual eligibility requirements.

A. Individuals receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.211, 435.217, and 435.230. The income level used for 42 CFR 435.211, 435.217 and 435.230 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care 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 waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining 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 will reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed below:

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

(1) The basic maintenance needs for an individual under both this waiver and the Mental Retardation Day Support waiver, which is equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual 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% SSI; for an individual employed at least eight 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. 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. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)

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

(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 state law but not covered under the plan.

b. For individuals to whom § 1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual individual under both this waiver and the Mental Retardation Day Support waiver, which is equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual 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% SSI; for an individual employed at least eight 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. 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. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children, which shall be equal to the Title XIX medically needy income standard based on the number of dependent children.

(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 Medical Assistance Plan.

3. The following four criteria shall apply to all mental retardation waiver services:

a. Individuals qualifying for mental retardation waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. The need for the service must arise from either (i) an individual having a diagnosed condition of mental retardation or (ii) a child younger than six years of age being at developmental risk of significant functional limitations in major life activities;

b. The CSP and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be recommended by the case manager based on a current functional assessment using a DMHMRSAS approved assessment instrument and a demonstrated need for each specific service; and

d. Individuals qualifying for mental retardation waiver services must meet the ICF/MR level of care criteria.

B. Assessment and enrollment.

1. To ensure that Virginia's home and community-based waiver programs serve only individuals who would otherwise be placed in an ICF/MR, home and community-based waiver

services shall be considered only for individuals who are eligible for admission to an ICF/MR with a diagnosis of mental retardation, or who are under six years of age and at developmental risk. For the case manager to make a recommendation for waiver services, MR Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR, or promote exiting from either an ICF/MR placement or other institutional placement.

2. The case manager shall recommend the individual for home and community-based waiver services after completion of a comprehensive assessment of the individual's needs and available supports. This assessment process for home and community-based waiver services by the case manager is mandatory before Medicaid will assume payment responsibility of home and community-based waiver services. The comprehensive assessment includes:

a. Relevant medical information based on a medical examination completed no earlier than 12 months prior to the initiation of waiver services;

b. The case manager’s functional assessment that demonstrates a need for each specific service. The functional assessment must be a DMHMRSAS approved assessment completed no earlier than 12 months prior to enrollment;

c. The level of care required by applying the existing DMAS ICF/MR criteria (12VAC 30-130-430 et seq.) completed no more than six months prior to enrollment. The case manager determines whether the individual meets the ICF/MR criteria with input from the individual, and their family/caregiver, as appropriate, and service and support providers involved in the individual's support in the community; and

d. A psychological evaluation or standardized developmental assessment for children under six years of age that reflects the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

3. The case manager shall provide the individual, and their family/caregiver, as appropriate with the choice of MR waiver services or ICF/MR placement.

4. The case manager shall send the appropriate forms to DMHMRSAS to enroll the individual in the MR Waiver or, if no slot is available, to place the individual on the waiting list. DMHMRSAS shall only enroll the individual if a slot is available. If no slot is available, the individual's name will be placed on either the urgent or nonurgent statewide waiting list until such time as a slot becomes available. Once notification has been received from DMHMRSAS that the individual has been placed on either the urgent or nonurgent waiting list, the case manager must notify the individual in writing within 10 business days of his placement on either list, and offer appeal rights. The case manager will contact the individual and their family/caregiver, as appropriate, at least annually to provide the choice between institutional placement and waiver services while the individual is on the waiting list.

C. Waiver approval process: authorizing and accessing services.

1. Once the case manager has determined an individual meets the functional criteria for mental retardation (MR) waiver services, has determined that a slot is available, and that the individual has chosen MR waiver services, the case manager shall submit enrollment information to DMHMRSAS to confirm level of care eligibility and the availability of a slot

2. Once the individual has been enrolled by DMHMRSAS, the case manager will submit a DMAS-122 along with a written confirmation from DMHMRSAS of level of care eligibility, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities.

3. After the case manager has received written notification of Medicaid eligibility by DSS and written confirmation of enrollment from DMHMRSAS, the case manager shall inform the individual and their family/caregiver, as appropriate, so that the CSP can be developed. The individual and their family/caregiver, as appropriate, will meet with the case manager within 30 calendar days to discuss the individual's needs and existing supports, and to develop a CSP that will establish and document the needed services. The case manager shall provide the individual and their family/caregiver, as appropriate, with choice of needed services available under the MR Waiver, alternative settings and providers. A CSP shall be developed for the individual based on the assessment of needs as reflected in the level of care and functional assessment instruments and the individual’s and their family/caregiver’s, as appropriate, preferences. The CSP development process identifies the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered.

4. The individual or case manager shall contact chosen service providers so that services can be initiated within 60 days of receipt of enrollment confirmation from DMHMRSAS. The service providers in conjunction with the individual, and the individual’s family/caregiver, as appropriate, and case manager will develop ISPs for each service. A copy of these plans will be

submitted to the case manager. The case manager will review and ensure the ISP meets the established service criteria for the identified needs prior to submitting to DMHMRSAS for prior authorization. The ISP from each waiver service provider shall be incorporated into the CSP. Only MR Waiver services authorized on the CSP by DMHMRSAS according to DMAS policies may be reimbursed by DMAS.

5. The case manager must submit the results of the comprehensive assessment and a recommendation to the DMHMRSAS staff for final determination of ICF/MR level of care and authorization for community-based services. DMHMRSAS shall, within 10 working days of receiving all supporting documentation, review and approve, pend for more information, or deny the individual service requests. DMHMRSAS will communicate in writing to the case manager whether the recommended services have been approved and the amounts and type of services authorized or if any have been denied. Medicaid will not pay for any home and community-based waiver services delivered prior to the authorization date approved by DMHMRSAS if prior authorization is required.

6. MR Waiver services may be recommended by the case manager only if:

a. The individual is Medicaid eligible as determined by the local office of the Department of Social Services;

b. The individual has a diagnosis of mental retardation as defined by the American Association on Mental Retardation, Mental Retardation: Definition, Classification, and System of Supports, 10th Edition, 2002, or is a child under the age of six at developmental

risk, and would in the absence of waiver services, require the level of care provided in an ICF/MR the cost of which would be reimbursed under the Plan; and,

c. The contents of the individual service plans are consistent with the Medicaid definition of each service.

7. All consumer service plans are subject to approval by DMAS. DMAS is the single state agency authority responsible for the supervision of the administration of the MR Waiver.

8. If services are not initiated by the provider within 60 days, the case manager must submit written information to DMHMRSAS requesting more time to initiate services. A copy of the request must be provided to the individual and the individual's family/caregiver, as appropriate. DMHMRSAS has the authority to approve the request in 30-day extensions, up to a maximum of four consecutive extensions, or deny the request to retain the waiver slot for that individual. DMHMRSAS shall provide a written response to the case manager indicating denial or approval of the extension. DMHMRSAS shall submit this response within 10 working days of the receipt of the request for extension.

D. Reevaluation of service need.

1. The consumer service plan (CSP).

a. The CSP shall be developed annually by the case manager with the individual, and their family/caregiver, as appropriate, other service providers, consultants, and other interested parties based on relevant, current assessment data.

b. The case manager is responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the CSP as indicated by the changing needs of the individual. At a minimum, the case manager must review the CSP every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

c. Any modification to the amount or type of services in the CSP must be preauthorized by DMHMRSAS or DMAS.

2. Review of level of care.

a. The case manager shall complete a reassessment annually in coordination with the individual, and their family/caregiver, as appropriate, and service providers. The reassessment shall include an update of the level of care and functional assessment instrument and any other appropriate assessment data. If warranted, the case manager shall coordinate a medical examination and a psychological evaluation for the individual. The CSP shall be revised as appropriate.

b. A medical examination must be completed for adults based on need identified by the individual, and their family/caregiver, as appropriate, provider, case manager, or DMHMRSAS staff. Medical examinations and screenings for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

c. A new psychological evaluation shall be required whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation. A psychological evaluation or standardized developmental assessment for

children under six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities.

3. The case manager will monitor the service providers' ISPs to ensure that all providers are working toward the identified goals of the affected individuals.

4. Case managers will be required to conduct monthly onsite visits for all MR waiver individuals residing in DSS-licensed assisted living facilities or approved adult foster care placements.

5. The case manager must obtain an updated DMAS-122 form from DSS annually, designate a collector of patient pay when applicable and forward a copy of the updated DMAS-122 form to all service providers and the consumer-directed fiscal agent if applicable.

CERTIFIED:
I hereby certify that these regulations are full, true and correctly dated.

_____ _____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-120-720. Recipient qualification and eligibility requirements; intake process.

A. Recipients receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.121 and 435.217. The income level used for 42 CFR 435.121 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care criteria. The deeming rules are applied to waiver eligible recipients as if the recipient 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 individual's total income (including amounts disregarded in determining 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 will reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

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

(1) The basic maintenance needs for an individual, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% 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 spouse at home, the community spousal income allowance 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 determined in accordance with §1924(d) of the Social Security Act.

(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 state law but not covered under the Plan.

b. For individuals to whom §1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% 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 dependent child or children, an additional amount for the maintenance needs of the child or children which shall be equal to the medically needy income standard based on the number of dependent children.

(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 medical assistance plan.

B. Assessment and authorization of home and community-based care services.

1. To ensure that Virginia's home and community-based care waiver programs serve only recipients who would otherwise be placed in an ICF/MR, home and community-based care services shall be considered only for individuals who are eligible for admission to an ICF/MR, absent a diagnosis of mental retardation. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in an ICF/MR.

2. The recipient's status as an individual in need of IFDDS home and community-based care services shall be determined by the IFDDS screening team after completion of a thorough assessment of the recipient's needs and available support. Screening of home and community-based care services by the IFDDS screening team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

3. The IFDDS screening team shall gather relevant medical, social, and psychological data and identify all services received by the recipient. For children to transfer to the IFDDS Waiver at age six, case managers shall submit to DMAS the child's most recent Level of Functioning form, the CSP, and a psychological examination completed no more than one year prior to the child's sixth birthday if they are receiving MR Waiver services. Such documentation must demonstrate that no diagnosis of mental retardation exists in order for this transfer to the IFDDS Waiver to be approved.

4. The case manager shall be responsible for notifying DMAS, DMHMRSAS, and DSS, via the DMAS-122, when a child transfers from the MR Waiver to the IFDDS Waiver.

5. Children under six years of age shall not be screened until three months prior to the month of their sixth birthday. Children under six years of age shall not be added to the waiver/wait list until the month in which their sixth birthday occurs.

6. An essential part of the IFDDS screening team's assessment process is determining the level of care required by applying existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.).

7. The team shall explore alternative settings and services to provide the care needed by the individual. If placement in an ICF/MR or a combination of other services is determined to be appropriate, the IFDDS screening team shall initiate a referral for service. If Medicaid-funded home and community-based care services are determined to be the critical service to delay or avoid placement in an ICF/MR or promote exiting from an institutional setting, the IFDDS screening team shall initiate a referral for service to a support coordinator of the recipient's choice.

8. Home and community-based care services shall not be provided to any individual who also resides in a nursing facility, an ICF/MR, a hospital, an adult family home licensed by the DSS, or an assisted living facility licensed by the DSS.

9. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by DMAS. Any Consumer Service Plan for home- and community-

based care services must be pre-approved by DMAS prior to Medicaid reimbursement for waiver services.

10. The following five criteria shall apply to all IFDDS Waiver services:

a. Individuals qualifying for IFDDS Waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. In order to be eligible, a person must be six years of age or older, have a related condition as defined in these regulations and cannot have a diagnosis of mental retardation, and who would, in the absence of waiver services, require the level of care provided in an ICF/MR facility, the cost of which would be reimbursed under the Plan;

b. The Consumer Service Plan and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the support coordinator based on a current functional assessment tool approved by DMAS or other DMAS approved assessment and demonstrated need for each specific service;

d. Individuals qualifying for IFDDS Waiver services must meet the ICF/MR level of care criteria; and

e. The individual must be eligible for Medicaid as determined by the local office of DSS.

11. The IFDDS screening teams must submit the results of the comprehensive assessment and a recommendation to DMAS staff for final determination of ICF/MR level of care and authorization for community-based care services.

C. Screening for the IFDDS Waiver.

1. Individuals requesting IFDDS Waiver services will be screened and will receive services on a first-come, first-served basis in accordance with available funding based on the date the recipients' applications are received. Individuals who meet at least one of the emergency criteria pursuant to 12VAC30-120-790 shall be eligible for immediate access to waiver services if funding is available.

2. To be eligible for IFDDS Waiver services, the individual must:

a. Be determined to be eligible for the ICF/MR level of care;

b. Be six years of age or older,

c. Meet the related conditions definition as defined in 42 CFR 435.1009 or be diagnosed with autism; and

d. Not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR) as contained in 12VAC30-120-710.

D. Waiver approval process: available funding.

1. In order to ensure cost effectiveness of the IFDDS Waiver, the funding available for the waiver will be allocated between two budget levels. The budget will be the cost of waiver services only and will not include the costs of other Medicaid covered services. Other Medicaid services, however, must be counted toward cost effectiveness of the IFDDS Waiver. All services available under the waiver are available to both levels.

2. Level one will be for individuals whose comprehensive consumer service plan (CSP) is expected to cost less than $25,000 per fiscal year. Level two will be for individuals whose CSP is expected to cost equal to or more than $25,000. There will not be a threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF/MR care for an individual, the recipient's care will be coordinated by DMAS staff.

3. Fifty-five percent of available waiver funds will be allocated to budget level one, and 40% of available waiver funds will be allocated to level two in order to ensure that the waiver will be cost effective. The remaining 5.0% of available waiver funds will be allocated for emergencies as defined in 12VAC30-120-790. Recipients who have been placed in budget level one and who subsequently require additional services that would exceed $25,000 per fiscal year must meet the emergency criteria as defined in 12VAC30-120-790 to receive additional funding for services.

E. Waiver approval process: accessing services.

1. Once the screening entity has determined that an individual meets the eligibility criteria for IFDDS Waiver services and the individual has chosen this service, the screening entity will provide the individual with a list of available support coordinators. For MR Waiver recipients

transferring to the IFDDS Waiver, the case manager must provide the recipient or family/caregiver with a list of support coordinators. The individual or family/caregiver will choose a support coordinator within 10 calendar days of receiving the list of support coordinators and the screening entity/case manager will forward the screening materials, CSP, and all MR Waiver related documentation within 10 calendar days of the coordinator's selection to the selected support coordinator.

2. The support coordinator will contact the recipient within 10 calendar days of receipt of screening materials. The support coordinator and the recipient or recipient's family will meet within 30 calendar days to discuss the recipient's needs, existing supports and to develop a preliminary consumer service plan (CSP) which will identify services needed and will estimate the annual waiver cost of the recipient's CSP. If the recipient's annual waiver cost is expected to exceed the average annual cost of ICF/MR care for an individual, the recipient's support coordination will be managed by DMAS.

3. Once the CSP has been initially developed, the support coordinator will contact DMAS to receive prior authorization to enroll the recipient in the IFDDS Waiver. DMAS shall, within 14 days of receiving all supporting documentation, either approve for Medicaid coverage or deny for Medicaid coverage the CSP. DMAS shall only authorize waiver services for the recipient if funding is available for the entire CSP. Once this authorization has been received, the support coordinator shall inform the recipient so that the recipient can begin choosing service providers for services listed in the CSP. If DMAS does not have the available funding for this recipient, the

recipient will be held on the waiting list until such time as funds are available to cover the cost of the CSP.

4. Once the recipient has been authorized for the waiver, the recipient or support coordinator shall contact service providers and initiate services within 60 days. During this time, the consumer, support coordinator, and service providers will meet to complete the CSP. If services are not initiated within 60 days, the support coordinator must submit information to DMAS demonstrating why more time is needed to initiate services. DMAS has authority to approve or deny the request in 30-day extensions. The service providers will develop supporting documentation for each service and will submit a copy of these plans to the support coordinator. The support coordinator will monitor the service providers' supporting documentation to ensure that all providers are working toward the identified goals of recipients. The support coordinator will review and sign off on the supporting documentation and will contact DMAS for prior authorization of services and will notify the service providers when services are approved.

5. The support coordinator will contact the recipient at a minimum on a monthly basis and as needed to coordinate services and maintain the recipient's CSP. DMAS will conduct annual level of care reviews in which the recipient is assessed to ensure he continues to meet waiver criteria. DMAS will review recipients' CSPs and will review the services provided by support coordinators as well as service providers.

CERTIFIED:

I hereby certify that these regulations are full, true and correctly dated.

_____ _____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-920. Individual eligibility requirements.

A. 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 will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care 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 individual's total income (including amounts disregarded in determining 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 will reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For 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 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 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 individuals employed at least eight 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 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. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.);

(2) For an individual with only a spouse at home, the community spousal income allowance 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 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 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 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 individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight 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. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.);

(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.

B. Assessment and authorization of home and community-based services.

1. To ensure that Virginia's home and community-based waiver programs serve only Medicaid eligible individuals who would otherwise be placed in a nursing facility, home and community-based waiver services shall be considered only for individuals who are eligible for admission to a nursing facility. 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 nursing facility.

2. The individual's eligibility for home and community-based services shall be determined by the Preadmission Screening Team after completion of a thorough assessment of the individual's needs and available support. If an individual meets nursing facility criteria, the Preadmission Screening Team shall provide the individual and family/caregiver with the choice of Elderly or Disabled with Consumer Direction Waiver services or nursing facility placement.

3. The Preadmission Screening Team shall explore alternative settings or services to provide the care needed by the individual. When Medicaid-funded home and community-based care services are determined to be the critical services necessary to delay or avoid nursing facility placement, the Preadmission Screening Team shall initiate referrals for services.

4. Medicaid will not pay for any home and community-based care services delivered prior to the individual establishing Medicaid eligibility and prior to the date of the preadmission screening by the Preadmission Screening Team and the physician signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96).

5. Before Medicaid will assume payment responsibility of home and community-based services, preauthorization must be obtained from the designated preauthorization contractor on all services requiring preauthorization. Providers must submit all required information to the designated preauthorization contractor within 10 business days of initiating care or within 10 business days of receiving verification of Medicaid eligibility from the local DSS. If the provider submits all required information to the designated preauthorization 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 Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96). If the provider does not submit all required information to the designated preauthorization contractor within 10 business days of initiating care, the services may be authorized beginning with the date all required information was received by the designated preauthorization contractor, but in no event preceding the date of the Preadmission Screening Team physician's signature on the DMAS-96 form.

6. Once services for the individual have been authorized by the designated preauthorization contractor, the provider/services facilitator will submit a Patient Information Form (DMAS-122), along with a written confirmation of level of care eligibility from the designated preauthorization contractor, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities. After the provider/services facilitator has received written notification of Medicaid eligibility by DSS and written enrollment from the designated preauthorization contractor, the provider/services facilitator shall inform the individual or family/caregiver so that services may be initiated.

7. The provider/services facilitator with the most billable hours must request an updated DMAS-122 form from the local DSS annually and forward a copy of the updated DMAS-122 form to all service providers when obtained.

8. Home and community-based care services shall not be offered or provided to any individual who resides in a nursing facility, an intermediate care facility for the mentally retarded, a hospital, an assisted living facility licensed by DSS or an Adult Foster Care provider certified by DSS, or a group home licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Additionally, home and community-based care services shall not be provided to any individual who resides outside of the physical boundaries of the Commonwealth, with the exception of brief periods of time as approved by DMAS or the designated preauthorization contractor. Brief periods of time may include, but are not necessarily restricted to, vacation or illness.

C. Appeals. Recipient appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

CERTIFIED:
I hereby certify that these regulations are full, true and correctly dated.

_____	_____
Date	Patrick W. Finnerty, Director Dept. of Medical Assistance Service