COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Usha Koduru** UK
Assistant Attorney General
Office of the Attorney General

DATE: **May 9, 2016**

SUBJECT: **Proposed regulation updating the Technology Assisted Waiver Program 12 VAC 30-120-1700 et seq.**

I have reviewed the attached proposed regulations to accommodate changes in the home healthcare industry and provide additional flexibility to families and provider agencies when attempting to staff authorized skilled private duty nursing hours. Based on that review, it is my view that the Director, acting on behalf of the Board pursuant to Virginia Code § 32.1-325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Virginia Code § 32.1-325 grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance, and §§ 32.1-324 and 325 grant the authority to the Director to administer the Plan according to the Board's requirements. Additionally, Section 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payment for Medicaid services. Section 1915(c) permits states to cover home and community-based services that enable qualifying individuals to live in their communities and

avoid institutionalization. These services are eligible for federal matching funds. These regulations require approval by the Centers for Medicare and Medicaid Services.

If you have any additional questions, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

VIRGINIA
REGULATORY TOWN HALL

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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-120-1700 et seq.
Regulation title(s)	Waiver Services: Home and Community-Based Services for Technology Assisted Waiver
Action title	2015 Technology Assisted Waiver Updates
Date this document prepared	February 19, 2016

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

The purpose of this action is to update the Department of Medical Assistance Services' (DMAS') Technology Assisted Waiver (TW) regulations (12 VAC 30-120-1700 et seq.) to accommodate changes in the home healthcare industry and provide additional flexibility to families and provider agencies when attempting to staff authorized skilled private duty nursing (PDN) hours. These options are expected to increase the availability of adequately trained skilled nurses who provide services to this medically complex population.

Proposed changes to the regulations include: (i) modifying the staff experience requirement to substitute a quality training program for nurses in place of the current six months of clinical experience; (ii) permitting families greater flexibility to use their authorized private duty nursing

hours over the span of a week rather than limiting them to 16 hours of private duty nursing services in a 24-hour period; and (iii) removing the current option of making up or rescheduling missed nursing hours.

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Section 1915(c) of the *Social Security Act* permits states to cover an array of home and community-based services that enable qualifying individuals to live in their communities thereby avoiding institutionalization. These community services are eligible for federal matching funds. The Technology Assisted Waiver (TW) is one of DMAS' programs operating under this federal authority.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The Technology Waiver (TW) serves individuals who require some form of mechanical device, such as ventilators, to sustain life. The waiver regulations require updating to ensure that they reflect best health care practices. These changes are expected to provide greater access to waiver services while ensuring the health, safety, and welfare of all individuals receiving TW services.

Substance

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

The Medicaid waiver regulations that are affected by this action are: 12VAC30-120-1710, 12VAC30-120-1720, 12VAC30-120-1730 and 12VAC30-120-1740.

CURRENT POLICY (1)

The TW currently requires all nurses (Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), who are reimbursed for rendering skilled private duty nursing services to TW individuals, have at least six months of clinical experience that is comparable to the care needs of the assigned TW individuals. This experience must be acquired prior to providing skilled private duty nursing services or skilled private duty respite services for Medicaid reimbursement in this waiver program.

ISSUES

Nationally, as well as in Virginia, there is a nursing shortage. TW providers, such as home health agencies and nursing agencies, are having difficulty finding nurses with 6 months of specialized clinical experience in the complex care required by Tech Waiver individuals (ventilators, tracheostomies, nasogastric tubes, etc.). As more individuals with complex medical needs choose to remain in their communities, the shortage of experienced complex care nurses who can meet these individuals' service needs is further strained.

In part, this nursing shortage has occurred as a result of advances in the care of ventilator-dependent individuals who live in their communities. Individuals choosing to receive care in communities (rather than in institutions) has reduced the number of nursing facilities (NFs) and NF specialized care ventilator units where nurses may receive training and experience. Additionally, acute care hospitals have shifted many of the responsibilities for direct respiratory care and tracheostomy/ventilator maintenance from staff nurses to respiratory therapists thereby further reducing opportunities for nurses to acquire experience.

CURRENT POLICY (2)

DMAS currently requires that families provide at least 8 hours of care in every 24-hour day to TW individuals. In the past, there have been concerns about the waiver individuals' health and safety as well as these individuals' care costs exceeding, in the aggregate, institutional costs. Should this happen, the federal funding agency, the Centers for Medicare and Medicaid Services (CMS), will withdraw federal funding for this community waiver resulting in many of these waiver individuals being moved into institutions.

ISSUES

Families have stated that, while remaining within their weekly authorized number of private duty nursing hours, it should not matter when the nursing hours are used: whether the hours are consolidated over just a few days in the week (assuming that home health/nursing agencies can provide enough nursing staff) or spread out over the entire week. These families and caregivers have argued that it is difficult for them to find employment when they cannot commit to regular, consistent work schedules for their employers.

In addition, CMS is generally requiring Medicaid programs to have person-centered approaches for all service delivery. DMAS believes that keeping this waiver's expenditures below the institutional care costs can be maintained while permitting these individuals and their families greater flexibility in when authorized skilled private duty nursing services are used.

CURRENT POLICY (3)

When a skilled private duty nurse cancels thier scheduled work shift (due to illness or family issues) with the TW individual, it is considered to be 'missed' nursing hours. DMAS currently allows TW individuals to "make up" missed authorized private duty nursing (PDN) hours within the same week (Sunday through Saturday) of the missed shift. The total number of provided PDN hours and made up hours cannot exceed 16 hours per day.

ISSUES

With the change in the policy allowing families greater flexibility in scheduling their authorized hours per week, a policy to make up missed hours is no longer required. If previously scheduled hours are not covered by the skilled private duty nurse, the family still has those hours available within their weekly total authorized hours to schedule on another day during that same week. This rescheduling of the "missed" coverage hours falls within their ability to "flex" their schedule and would not be considered make-up.

RECOMMENDATIONS

(1) DMAS recommends permitting providers to employ nurses (both RNs and LPNs) who have either six months of related clinical experience or who have completed a relevant provider training program. The regulations stipulate the required elements of the training. The trainer may be either a licensed Registered Nurse or a licensed Respiratory Therapist who has at least 6 months hands-on experience in the area of care to be provided (such as ventilator, tracheostomy, peg tube, nasogastric tube, etc.). A satisfactory training program will include classroom time as well as direct hands-on demonstration of skills by trainees. Training must include the following subject areas related to the care to be provided: (i) human anatomy and physiology; (ii) frequently used medications for this population of individuals; (iii) emergency management; and, (iv) operation of equipment. The provider must ensure competency of staff.

Allowing providers to substitute a quality/relevant nurse training program in lieu of the current six months of clinical experience is expected to increase the pool of potential nurses (RNs/LPNs) eligible to provide TW services.

(2) DMAS recommends changing the policy that families/caregivers provide at least 8 hours of care in a 24-hour day to permit them to use DMAS-approved hours across a week. Such flexibility allows TW individuals' schedules to include longer work days to accommodate physician appointments, community activities, caregiver work schedules, etc. A sample schedule for a TW individual that allows caregiver coverage for work but also extended hours for community involvement may be, for example:

Week	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Week Total
Agency	8	16	20	16	20	16	16	112
Family	16	8	4	8	4	8	8	56

(3) DMAS recommends deleting the current wording related to make up or re-scheduling of missed hours as it is no longer germane.

These recommendations do not expand the existing service coverage limits for skilled private duty nursing or private duty respite services.

Other recommended text changes update language to improve readability and comprehension.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

DMAS proposes to update the Technology Assisted Waiver (TW) regulations in order to allow its program to accommodate changes in the industry and provide additional options to agencies for staffing of skilled private duty nursing/respite services while preserving the health, safety and welfare of TW individuals. In response to providers' requests, DMAS is considering permitting the substitution of training for private duty nurses in place of clinical experience. In response to families' requests, DMAS is also considering permitting families to use their authorized private duty nursing hours over the span of a week rather than limiting them to 16 hours of private duty nursing services in a 24-hour period.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements more restrictive than existing federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

There are no localities that are uniquely affected by this action as these changes will apply statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to: Roberta Matthews, RN, Div. of LTC Services, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA. 23219; 804-786-5419 (phone); 804-786-1680 (fax); Roberta.Matthews@dmas.virginia.gov .

Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including: **a) fund source / fund detail; and** **b) a delineation of one-time versus on-going expenditures**	No cost to the Commonwealth to implement and enforce proposed changes.
Projected cost of the new regulations or changes to existing regulations on localities.	No cost to localities as a result of the changes to the TW regulations as they apply statewide.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	Individuals and their caregivers receiving and agencies providing medically complex services through the Technology Assisted Waiver program.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Approximately 143 private duty nursing provider agencies will be affected. Provider agencies will have the choice of implement-ting the proposed change related to training for nurses in lieu of required experience. This change should increase the number of nurses eligible to provide TW services. DMAS does not retain data on which of its providers are classified as small businesses.

All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: **a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and** **b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.**	a) Foreseeable costs related to proposed changes to the regulations include: (i) A possible small increase in the number of staff employed by an agency thus enabling agencies to provide more TW services. This is what providers want; (ii) A slight increase in the training cost of an agency that would be offset by the decrease in current advertising costs for nurses with the 6 months experience. (iii) With the flexibility of training nurses as well as staffing hours within a 112 hour per week window vs. a 24-hour per day window, the number of authorized hours actually provided could increase in comparison to current coverage levels. Thus may slightly increase over-all waiver costs for DMAS while remaining under the institutional cost cap. b) Proposed changes to TW regulations will require no costs related to development of real estate.
Beneficial impact the regulation is designed to produce.	The proposed changes will provide for improved nursing coverage and increased flexibility with hours based on TW individual's needs. This will make it easier for individuals to get the needed skilled private duty nursing and respite services.

Alternatives

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

There are no other alternatives that would increase the number of qualified nurses that are hired by enrolled providers as DMAS has no mechanism to affect this process. Families have specifically requested the additional flexibility to use their authorized private duty nursing hours in a week timespan.

Regulatory flexibility analysis

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

Technology Waiver provider agencies are experiencing increasing difficulty finding nurses who meet the current 6-months related clinical experience requirement prior to providing nursing services to TW individuals. This difficulty represents a shift in roles and responsibilities within today's general realm of medical practice which has resulted in fewer opportunities for nurses to receive adequate experience with individuals dependent on life sustaining equipment. Proposed changes to the TW regulations will allow providers a second, less stringent option of offering nurses comprehensive training which will meet the needs of this medically complex population. Providers, who choose to implement a training program for their nurses, must assure that the health, safety, and welfare of the served TW individuals continues to be met. Training programs developed by providers will be required to contain certain elements as specified within the proposed changes to the TW regulations.

Also with the proposed changes, TW individuals will be afforded increased flexibility in receiving nursing coverage based on their schedule needs without the stricter, daily limitations imposed by the current Tech Waiver regulations.

All of the proposed changes will result in less stringent policy than current requirements making it easier for providers to increase their number of trained nurses available to staff TW individuals' authorized nursing hours.

Small businesses are not exempt from the requirements contained in these proposed regulations.

Family Impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

DMAS filed its Notice of Intended Regulatory Action with the Office of the Registrar of Regulations on October 23, 2015, for publication in the Virginia Register on November 16, 2015

(VR 32:6). The comment period began on November 16, 2015 and ended on December 16, 2015. One comment was received as summarized below.

Commenter	Comment	Agency response
Individual	Proposed changes will improve agencies' chances of hiring additional nurses thus improving coverage for families caring for medically complex TW individuals at home.	Continue to pursue changes to regulations as currently proposed.

Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please list separately: (1) all differences between the **pre**-emergency regulation and this proposed regulation; and 2) only changes made since the publication of the emergency regulation.*

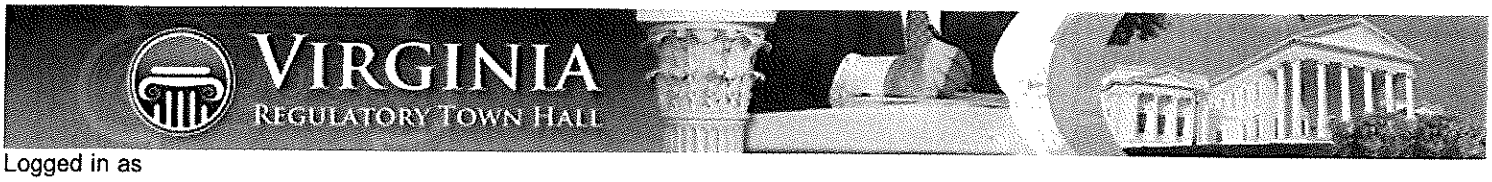
Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12VAC30-120-1710 A9		Caregivers are responsible for providing care for the TW individual a minimum of 8 hours per 24 hour period as well as any hours not staffed by the nursing agency	Change: Change requirement of caregivers to provide at least 8 hours of care per day to authorization of skilled PDN hours on a weekly basis. Caregivers will continue to provide care during any hours not authorized or staffed by the nursing agency. **Likely impact:** will provide for increased flexibility in usage of nursing hours by TW individual.
12VAC30-120-1710B5		Time frames for PAS screenings not included in regulations.	Change: Adds information on how long a PAS is valid, as well as requirements for breaks in service. **Likely impact:** Greater clarity for providers on the timeframes for PAS screenings.
12VAC30-120-1720 B1c		TW individuals may not have a Plan of Care (POC) or multiple POCs that authorize more than 16	Change: Remove maximum of 16 hours of skilled PDN per 24-hour period and add maximum coverage of 112 hours of skilled PDN per week.

		hours of PDN in a 24 hour period per household	**Likely impact:** TW individuals/ families will be able to coordinate the usage of their approved weekly skilled PDN hours with their nursing agency without being limited to a maximum number of hours per day.
12VAC30-120-1720 B1c(2)		TW pediatric individuals' authorized hours per day of skilled PDN is determined by their total score on the Pediatric Criteria (DMAS-109) form and LOC designation.	Change: Pediatric individuals' hours per week will be determined by their total score on the DMAS-109 form and their LOC designation. **Likely impact:** This will provide pediatric TW individuals/caregivers greater flexibility and control over usage of their skilled PDN hours.
12VAC30-120-1720 B1c(3)(a)(b)(c)		TW pediatric individuals' maximum authorized hours per day of skilled PDN are based on 3 levels of total points: (a) 50-56 points = 10 hours per day (b) 57-79 points = 12 hours per day (c) 80 points or greater = 16 hours per day	Change: Total points scored on the Pediatric Criteria Form (DMAS 109) will determine approved hours per week instead of hours /day. (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 **Likely impact:** This will provide TW individuals/caregivers with greater flexibility and control over usage of their skilled PDN hours.
12VAC30-120-1720 B1c(4)		Minor TW individuals may be authorized for up to 24 hours/day of PDN during the first 15 calendar days following initial admission. After this initial 15 day period, PDN may be reimbursed up to a maximum of 16 hours per 24-hour period per household based on the total score on the DMAS 109 and cost effectiveness.	Change: Following the initial 15 calendar day period, ongoing hours for minor individuals will be authorized up to a maximum of 112 hours per week based on their total score on the DMAS-109 form and cost effectiveness. **Likely impact:** Change made to continue consistency of skilled PDN authorizations per week instead of per day.
12VAC30-120-1720		Missed hours may be made up within the same week of	Change: Delete wording related to make up of missed hours.

B1c(5)		the scheduled missed shift but the total of regularly scheduled hours and make-up hours cannot exceed 16 per day	**Likely impact:** The flexibility provided by authorizing hours per week will allow missed hours to be used at a later time within the same week as long as the total weekly authorization is not exceeded.
12VAC30-120-1720 B1c(6)		For TW adult individuals, whether living separately or in a congregate setting, skilled PDN may be reimbursed for a maximum of 16 hours/24 hour period per household based on the individuals' technology, medical justification, and cost effectiveness.	Change: For adult individuals, whether living separately or in a congregate setting, skilled PDN shall be reimbursed for up to 112 hours per week per TW individual in the household based on medical justification and cost effectiveness. **Likely impact:** Allows greater flexibility for TW adults to schedule nursing hours to meet their needs
12VAC30-120-1720 B1f(3)		In a congregate setting, the primary caregiver shall be shared and must provide at least 8 hours of care per 24 hours period as well as when nursing coverage is not available.	Change: Remove requirement of caregiver to provide at least 8 hours of care per 24 hour period. **Likely impact:** The requirement will be for caregivers to provide care whenever an agency nurse is not in the home, not a required number of hours per day.
12VAC30-120-1720 B5d(2)		The total number of combined skilled PDN and personal care hours reimbursed by DMAS in a 24-hour period cannot exceed 16.	Change: The total number of combined skilled PDN and personal care hours reimbursed by DMAS shall not exceed 112 hours per week. **Likely impact:** None, wording is consistent with proposed change to authorize skilled PDN hours per week
12VAC30-120-1720B6a and c		Transition services are referenced in relation to the Money Follows the Person program.	Change: Transition services are not exclusive to MFP and some language is stricken to clarify this. **Likely impact:** None. Wording change only.
12VAC30-120-1730 A27c-d		c. Nurses providing skilled PDN must be validly licensed to practice nursing in the Commonwealth and have at least 6 months	Change: Current section A27c-d is revised to be A27c-f. Option of provider training in lieu of experience is added with training elements required by DMAS.

		related clinical experience. LPN's shall be under the direct supervision of a RN. d. RN supervisors shall be licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience	c. RNs and LPNs providing skilled PDN shall be licensed to practice nursing in the Commonwealth. LPNs must be directly supervised by an RN. d. RNs and LPNs providing skilled PDN must have at least six months of related clinical experience **or** complete a provider training program related to the care and technology needs of the TW individual. e. Training programs established by the provider must include at a minimum the following elements: (1) Trainer must have at least 6-months hands on experience in area they are training (2) Training must include classroom time and hands on demonstration of skills mastery by the trainee. (3) Training program must include the following subject areas: (a) Human anatomy and physiology (b) Frequently used medications (c) Emergency management (d) Operation of Equipment (4) Providers must assure competency of nurses prior to assignment to a TW individual. Competency documentation must be kept in personnel record. f. RN supervisor shall be licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience **Likely impact:** Allowing providers to establish training courses for nurses who do not meet TW's six months experience requirement will increase the availability of knowledgeable nurses to be employed for TW cases.

12VAC30-120-1740 B4		Providers must employ or subcontract with and supervise RNs and LPNs who are currently licensed to practice nursing in the Commonwealth. Prior to assignment to TW individuals these nurses must have at least six months of related clinical nursing experience.	Change: Prior to assignment to TW individuals, RNs and LPNs must have at least six months of related clinical nursing experience **or** complete a provider training program related to the care of the TW individual as defined in 12VAC30-120-1730 A27e. Providers are responsible for assuring job skills mastery and competency of nurses assigned to TW individuals. **Likely impact:** Increases availability of knowledgeable, trained nurses for TW individuals. Maintains consistent wording of proposed change throughout regulations.



Proposed Text

Action: 2015 Technology Assisted Waiver Updates

Stage: Proposed

5/4/16 12:27 PM [latest]

12VAC30-120-1710

12VAC30-120-1710. Individual eligibility requirements; preadmission screening.

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 ~~PDN~~ 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 (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 (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 Pre-admission 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 ~~a minimum of eight hours of the individual's care in a 24-hour period as well as~~ all hours not provided by ~~an~~ the provider agency's RN or ~~an~~ 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. Preadmission screenings are considered valid for the following time frames for all LTC services. The following time frames apply to individuals who have been screened but have not received either institutional or community-based services during the periods shown below:~~

~~a. Zero to six months: screenings are valid and do not require updates;~~

~~b. Six months to 12 months: screening updates are required; however, no additional reimbursement is made by DMAS; and~~

~~c. Over 12 months: a new screening is required. Additional reimbursement shall be made by DMAS for the repeated screening.~~

5. A PAS is considered valid for the following time frames. 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 below.

a. Zero to 180 days: Screenings are valid and do not require revisions or a new screening.

b. 180 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. DMAS will cover 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 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 their 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 on-going services either through a nursing facility or a home and community based service program, the screening time frames 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
12VAC30-120-1720. Covered services; limits; changes to or termination of services.

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 ~~total points on the~~ age-appropriate Tech Waiver Referral Form ~~(DMAS-108)~~ (DMAS-108 or DMAS-109) and medical necessity. ~~In~~ 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 ~~16 hours of PDN in a 24-hour period per household or congregate group setting except for minor individuals during the first 15 calendar days after initial waiver admission, and where 16 scheduled PDN hours are not completed within a 24-hour period, the hours may be rescheduled and worked within the following 72 hours to support the primary caregiver~~ 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 DMAS 109 form. The maximum skilled PDN hours authorized per week for adult individuals shall be based on their technology and medical necessity justification documented on the DMAS-108 form.

(1) The number of skilled PDN hours for minor individuals shall be based on the total technology and nursing score on the DMAS ~~Tech Waiver Staff Assessment~~ 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 ~~day~~ week of skilled PDN that DMAS may allocate for a pediatric individual. Any hours beyond the approved maximum for such individual's LOC ~~must~~ 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 = ~~10 hours per day~~ 70 hours per week

(b) 57 79 points = ~~12 hours per day~~ 84 hours per week

(c) 80 points or greater = ~~16 hours per day~~ 112 hours per week

~~(3)~~ (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 ~~a~~ the maximum ~~of 16 hours per 24-hour period per household~~ 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.

~~(4)~~ (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).

~~(5) The making up or trading of any missed authorized hours of care may be done within the same week (Sunday through Saturday) of the missed scheduled shift but the total hours made up, including for any day, shall not exceed 16 hours per day for any reason.~~

(6) For adult individuals, whether living separately or in a congregate ~~group~~ setting, skilled PDN shall be reimbursed up to a maximum of ~~16 hours within a 24-hour period~~ 112 hours per week (Sunday through Saturday) per TW individual living in the ~~per~~ household based on the individual's ~~total~~ technology and ~~nursing scores~~ 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 12VAC30-120-1720.

(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 ~~at least eight hours of~~ all ~~skilled PDN care per 24 hours as well as all skilled PDN~~ care needs ~~in the absence of the provider agency~~ 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 ~~regardless of waiver~~ for individuals who are qualified for tech waiver services and regardless of whether the waiver individual changes waivers and ~~who have a~~ whose primary caregiver ~~who~~ 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 ~~may include, but shall not be limited to~~ includes: (i) all skilled nursing care as ordered on the physician-certified POC, assistance with ADLs/IADLs, (ii) administration of medications or other medical needs, and (iii) 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)~~ (360 hours per calendar year per household) shall apply ~~regardless of the waiver~~.

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 ~~a service provided for in~~ the State Plan shall not be purchased under the waiver as AT. Such examples ~~are, but shall not necessarily be limited to~~ 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 multiple wheelchair ramps or 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~~ PC aide is providing nonskilled care.

a. PC services are either of a supportive or health-related nature and ~~may include, but are not limited to~~ includes 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 ~~doumented~~ 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 PC aide gives to individuals to assist them in preparing for school or when they return home. DMAS shall not pay for the PC aide 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 ~~24-hour period~~ week shall not exceed ~~16~~ 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. ~~These~~

~~services shall include those set out in the MFP demonstration.~~

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. When the Money Follows the Person demonstration is terminated or expires by federal action, the portion of this service covered through MFP shall also terminate. The remaining transition services shall continue until modified.~~

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 ~~a~~ an acute care hospital for 30 days or more, the individual shall be discharged from waiver services ~~while he is in the hospital~~. When such hospitalization exceeds 30 days and upon hospital discharge, readmission to waiver services ~~requires~~ is required. ~~a~~ Such readmission requires reassessment by the ~~PAS~~ discharge team ~~for determination~~ that the individual ~~currently meets~~ continues to meet Medicaid eligibility, ~~functional~~ level of care criteria, and ~~specialized nursing facility waiver criteria~~ medical criteria on the DMAS 108/109 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
12VAC30-120-1730. General requirements for participating providers.

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. ~~In addition, the RN as well as all nurses~~ All RNs and LPNs providing ~~the~~ skilled PDN ~~service~~ services shall be currently ~~and validly~~ licensed to practice nursing in the Commonwealth ~~and have at least six months of related clinical experience, which may include work in acute care hospitals, long-stay hospitals, rehabilitative hospitals or specialized care nursing facilities~~. The LPN shall be under the direct supervision of an RN.

~~d. 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.~~

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 TW individual.

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

(1) Trainers (either RNs or Respiratory Therapists (RT)) shall have at least six months hands-on successful experience in the areas they are providing training in such as ventilators, tracheostomies, peg tubes, nasogastric tubes.

(2) Training shall include classroom time as well as direct hands-on demonstration of mastery of these skills by the trainee.

(3) This training program shall include the following subject areas as they relate to the care to be provided by the TW 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 these skills necessary to successfully care for TW individuals by the nurses prior to assigning them to a TW individual. Documentation of successful completion of such training course and mastery of these skills 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
12VAC30-120-1740. Participation standards for provision of services.

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 TW individual, the RN or LPN shall ~~and~~ have either: (i) at least six months of related clinical nursing experience~~, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility~~ or (ii) completed a provider training program related to the care and technology needs of the TW individual as defined in 12 VAC 30-120-1730(A). 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/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/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.