12VAC30-120-10. Definitions.

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

"Activities of daily living" means assistance with personal care tasks (i.e., bathing, dressing, toileting, etc.).

"Adult day health care ~~centers~~ center" means a participating provider which offers a community-based day program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those elderly and physically disabled individuals at risk of placement in a nursing facility.

"Adult day health care services" means services designed to prevent institutionalization by providing participants with health, maintenance, and coordination of rehabilitation services in a congregate daytime setting.

"Current functional status" means the individual's degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DSS" means the Department of Social Services.

"Designated preauthorization contractor" means the entity that has been contracted by DMAS to perform preauthorization of services.

"Direct marketing" means either (i) directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders fees;" (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible recipients as inducements to use their services; (v) continuous, periodic marketing activities to the same prospective recipient, e.g., monthly, quarterly, or annual give-aways, as inducements to use their services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing recipients' use of providers' services.

"Episodic respite care" means relief of the primary unpaid caregiver for a non-routine, short-term period of time for a specified reason (i.e., respite care offered for seven days, 24 hours a day while the caregiver takes a vacation).

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS (personal care, adult day health care, ~~and~~ respite care, and personal emergency response systems (PERS) authorized under a § 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement. (PERS may only be provided in conjunction with personal care, respite care, or adult day health care services.) The Nursing Home Preadmission Screening Team or Department of Medical Assistance Services shall give prior authorization for any Medicaid-reimbursed home and community-based care.

"Medication monitoring" means an electronic device that enables certain recipients at high risk of institutionalization to be reminded to take their medication(s) at the correct dosage(s) and time(s).

"Nursing home preadmission screening" means the process to: (i) evaluate the ~~medical~~, functional, nursing, and social ~~needs~~ supports of individuals referred for preadmission screening~~,~~ ; (ii) analyze what specific services the individuals need~~,~~ ; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs~~,~~ ; and (iv) authorize Medicaid funded nursing home or community-based care for those individuals who meet nursing facility level of care ~~and require that level of care~~.

"Nursing Home Preadmission Screening Committee/Team" means the entity contracted with ~~the~~ DMAS ~~which~~ that is responsible for performing nursing home preadmission screening. For individuals in the community, this entity is a committee comprised of ~~staff from the local health department and local DSS~~ a nurse from the local health department and a social worker from the local department of social services. For individuals in an acute care facility who require screening, the entity is a team of nursing and social work staff. A physician must be a member of both the local committee ~~or~~ and an acute care team.

"Participating provider" means an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS.

"Personal emergency response system (PERS)" means an electronic device that enables certain recipients at high risk of institutionalization to secure help in an emergency.

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

"Personal care agency" means a participating provider which renders services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter a nursing care facility. Personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes.

"Plan of Care" means ~~the written plan certified by the screening team physician as needed by the individual to ensure optimal health and safety for the delivery of home and community- based care.~~ the plan developed by the provider related solely to the specific services required by the recipient to ensure optimal health and safety for the delivery of home and community based care.

"Service Plan" means the written plan certified by the screening team as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.

~~"Professional staff" means the director, activities director, registered nurse, or therapist of an adult day health care center.~~

"Respite care" means services specifically designed to provide a temporary, but periodic or routine, ~~but periodic or routine~~ relief to the primary unpaid caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. Respite care services include assistance with personal hygiene, nutritional support, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

"Respite care agency" means a participating provider which renders services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with respite care aides who provide respite care services.

"Routine respite care" means relief of the primary unpaid caregiver on a periodic basis over an extended period of time to allow the caregiver a routine break from continuous care (i.e., respite care offered one day a week for six hours).

~~"Staff" means professional and aide staff of an adult day health care center.~~

"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

12VAC30-120-20. General coverage and requirements for all home and community-based care waiver services.

A. Coverage statement.

1. Coverage shall be provided under the administration of the DMAS for elderly and disabled individuals who would otherwise require the level of care provided in a nursing facility.

2. These services shall be medically appropriate and necessary to maintain these individuals in the community.

3. Under this § 1915(c) waiver, DMAS waives §§ 1902(a)(10)(B) and ~~1902(a)(10)(C)(1)(iii)~~ 1902(a)(10)(C) of the Social Security Act related to comparability ~~and statewideness~~ of services.

B. Patient qualification and eligibility requirements.

1. ~~Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy and the medically needy. Virginia has elected to cover the optional categorically needy group under 42 CFR 435.211, 435.231 and 435.217. The income level used~~

~~for 435.211, 435.231 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person~~. Virginia has elected to cover low income families with children as described in section 1931 of the *Social Security Act*; Aged, Blind, or Disabled individuals who are eligible under 42 CFR § 435.121; optional Categorically Needy individuals who are Aged and Disabled who have incomes at 80% of the Federal Poverty Level**;** the special home and community-based waiver groups under 42 CFR § 435.217; and the Medically Needy under 42 CFR §§ 435.320, 435.322, 435.324, and 435.330.

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

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

1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed below:

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

(a) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a noninstitutionalized individual~~.~~ ;

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

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

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

2. For individuals to whom § 1924(d) does not apply, deduct the following in the following order:

(a) An amount for the maintenance needs of the individual which is equal to the categorically needy income standards for a noninstitutionalized individual~~.~~ ;

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

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

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

1. To ensure that Virginia's home and community-based care waiver programs serve only individuals who would otherwise be placed in a nursing facility, home and community-based

care services shall be considered only for individuals who are seeking nursing facility admission or for individuals who are at imminent risk of nursing facility admission. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in a nursing facility.

2. The individual's ~~status as an individual in need of~~ eligibility for home and community-based care services shall be determined by the Nursing Home Preadmission Screening Team after completion of a thorough assessment of the individual's needs and available support~~. Screening and preauthorization of home and community-based care services by the Nursing Home Preadmission Screening Committee/Team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.~~

3. Before Medicaid will assume payment responsibility of home and community based care services, preauthorization must be obtained from the designated preauthorization contractor.

~~3~~.4. An essential part of the Nursing Home Preadmission Screening Team's assessment process is determining the required level of care ~~required~~ by applying existing criteria for nursing facility care according to the established Nursing Home Preadmission Screening process.

~~4~~. 5. The team shall explore alternative settings and/or services to provide the care needed by the individual. If nursing facility placement or a combination of other services is determined to be

appropriate, the screening team shall initiate referrals for service. If Medicaid-funded home and community-based care services are determined to be the critical service to delay or avoid nursing facility placement, the screening team shall develop an appropriate service plan ~~of care~~ and initiate referrals for service.

~~5. Reserved.~~

6. Home and community-based care services shall not be offered to any individual who resides in a nursing facility, an intermediate facility for the mentally retarded, a hospital, or an adult home licensed or certified by the DSS.

7. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by the Nursing Home Preadmission Screening Committee/Team and the physician signature on the Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96). If services have not begun within 180 days of the preadmission screening, a new preadmission screening must be completed or an update to the original preadmission screening must be completed prior to the beginning of services.

~~8. Any authorization and Plan of Care for home and community-based care services will be subject to the approval of the DMAS prior to Medicaid reimbursement for waiver services.~~

12VAC30-120-30. General conditions and requirements for all home and community-based care participating providers.

A. General requirements. Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS, to include the provider's physical and mailing addresses, executive staff and officers, and contact person's name, telephone number, and fax number.

2. Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services were performed.

3. Assure the recipient's freedom to reject medical care and treatment.

4. Accept referrals for services only when staff is available to initiate services.

5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin and of Section 504 of the Rehabilitation Act of 1973 and the American with Disabilities Act, which ~~prohibits~~ prohibit discrimination on the basis of a handicap.

6. Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

7. Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

8. Accept Medicaid payment from the first day of eligibility.

9. Accept as payment in full the amount established by ~~the~~ DMAS.

10. Use Program-designated billing forms for submission of charges.

11. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

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

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

12. Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

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

14. Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients.

15. Change of ownership. When ownership of the provider agency changes, DMAS shall be notified within 15 calendar days.

B. Requests for participation. Requests will be screened to determine whether the provider applicant meets the basic requirements for participation.

C. Provider participation standards. For DMAS to approve contracts with home and community-based care providers ~~the following standards shall be met:~~ , providers must meet staffing, financial solvency, disclosure of ownership and assurance of comparability of services requirements as specified in DMAS guidelines.

~~1. Staffing requirements,~~

~~2. Financial solvency,~~

~~3. Disclosure of ownership, and~~

~~4. Assurance of comparability of services.~~

D. Adherence to provider contract and special participation conditions. In addition to compliance with the general conditions and requirements, all providers enrolled by the Department of Medical Assistance Services shall adhere to the conditions of participation outlined in their individual provider contracts.

E. Recipient choice of provider agencies. If there is more than one approved provider agency offering services in the community, the individual will have the option of selecting the provider agency of his ~~their~~ choice from among those agencies which can appropriately meet the individual's needs.

F. Termination of provider participation. DMAS may administratively terminate a provider from participation upon ~~60~~30 days' written notification. DMAS may also cancel a contract immediately or may give notification in the event of a breach of the contract by the provider as specified in the DMAS contract. ~~Subsection precludes further payment~~ Payment by DMAS is prohibited for services provided to recipients subsequent to the date specified in the termination notice.

G. Reconsideration of adverse actions. Adverse actions may include, but shall not be limited to: disallowed payment of claims for services rendered which are not in accordance with DMAS policies and procedures, caseload restrictions, and contract limitations or termination. The following procedures will be available to all providers when DMAS takes adverse action:

1. The reconsideration process shall consist of three phases:

a. A written response and reconsideration to the preliminary findings~~,~~ ;

b. The informal conference~~,~~ ; and

c. The formal evidentiary hearing.

2. The provider shall have 30 days to submit information for written reconsideration, ~~15~~30 days from the date of the notice to request the informal conference, and ~~15~~30 days to request the formal evidentiary hearing.

3. An appeal of adverse actions shall be heard in accordance with ~~the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of the final agency determination shall be~~

~~made in accordance with the Administrative Process Act~~ 12 VAC 30-10-1000 and 12 VAC 30-20-500 et seq.

H. Participating provider agency's responsibility for the recipient information form (DMAS-122). It is the responsibility of the provider agency to notify DMAS, or the designated preauthorization contractor, and the DSS, in writing, when any of the following circumstances occur:

1. Home and community-based care services are implemented~~,~~ ;

2. A recipient dies~~,~~ ;

3. A recipient is discharged or terminated from services~~,~~ ; or

4. Any other circumstances (including hospitalization) which cause home and community-based care services to cease or be interrupted for more than 30 days.

I. Changes or termination of care.

1. Decreases in the amount of authorized care by the provider agency.

a. The provider agency may decrease the amount of authorized care ~~only~~ if the ~~recipient and the participating provider both agree that a decrease in care is needed and that the~~ amount of care in the revised plan of care is appropriate , based on the needs of the individual. If the recipient disagrees with the proposed decrease, DMAS, or the designated preauthorization contractor, shall conduct a review of the recipient's service needs as part of the reconsideration process.

b. The participating provider is responsible for devising the new ~~Plan of Care~~ plan of care and calculating the new hours of service delivery.

c. The individual responsible for supervising the recipient's care shall discuss the decrease in care with the recipient or family, ~~or both,~~ document the conversation in the recipient's record, and shall notify the recipient or family of the change by letter. This letter shall give the right to reconsideration.

~~d. If the recipient disagrees with the decrease proposed, the DMAS shall be notified to conduct a special review of the recipient's service needs.~~

2. Increases in the amount of authorized care. If a change in the recipient's condition ~~(physical, mental, or social)~~ necessitates an increase in care, the participating provider shall assess the need for increase and, if appropriate, develop a plan of care for services to meet the changed needs. The provider may implement the increase in hours without approval from DMAS, or the designated preauthorization contractor, ~~as long as~~ if the amount of service does not exceed the amount established by DMAS , or the designated preauthorization contractor, as the maximum for the level of care designated for that recipient. Any increase to a recipient's plan of care which exceeds the number of hours allowed for that recipient's level of care, or any change in the recipient's level of care, must be preapproved by ~~the~~ DMAS, or the designated preauthorization contractor. ~~utilization review analyst assigned to the provider.~~

3. Nonemergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient or family, or both, five days written notification of the intent to terminate services. The letter shall provide the reasons for and the effective date of the termination. The effective date of ~~services~~ the termination of services shall be at least five days from the date of the termination notification letter.

4. Emergency termination of home and community-based care services by the participating provider. In an emergency situation when the health and safety of the recipient or provider

agency personnel is endangered ~~the~~ DMAS, or the designated preauthorization contractor, must be notified prior to termination. The five-day written notification period shall not be required.

5. DMAS, or the designated preauthorization contractor, termination of home and community-based care services. The effective date of termination will be at least 10 days from the date of the termination notification letter. DMAS, or the designated preauthorization contractor, has the responsibility and the authority to terminate home and community-based care services to the recipient for any of these reasons:

a. The home and community- based care service is not the critical alternative to prevent or delay institutional placement~~.~~;

b. The recipient no longer meets the level-of-care criteria~~.~~;

c. The recipient's environment does not provide for his health, safety, and welfare~~.~~; or

d. An appropriate and cost-effective plan of care cannot be developed.

J. Suspected abuse or neglect. Pursuant to § 63.1-55.3 of the Code of Virginia, if a participating provider agency knows or suspects that a home and community-based care recipient is being

abused, neglected, or exploited, the party having knowledge or suspicion of the ~~abuse/neglect/exploitation~~ abuse, neglect, or exploitation shall report this to the local DSS.

K. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring and ~~or~~ compliance with provider participation standards and DMAS policies. ~~and annually recertify each provider for contract renewal with DMAS to provide home and community-based services.~~ A provider's noncompliance with DMAS policies and procedures, as required in the provider's contract, may result in a retraction of Medicaid payment or termination of the provider agreement. ~~written request from DMAS for a corrective action plan which details the steps the provider will take and the length of time required to achieve full compliance with deficiencies which have been cited.~~

L. Waiver Desk Reviews. DMAS will request, on an annual basis, information on every recipient which is used to assess the recipient's ongoing need for Medicaid funded long-term care. With this request, the provider will receive a form (Level of Care Eligibility Review) that specifies the information that is being requested.

12VAC30-120-40. Adult day health care services.

The following are specific requirements governing the provision of adult day health care:

A. General. Adult day health care services may be offered to individuals in a congregate daytime setting as an alternative to more costly institutional care. Adult day health care may be offered either as the sole home and community-based care service that avoids institutionalization or in conjunction with personal care, ~~or~~ respite care, ~~or both~~or PERS. ~~When the individual referred for adult day health care is already receiving another home and community-based care service, the DMAS utilization review staff shall assess the need for the additional home and community-based care service and authorize the service if it is deemed necessary to avoid institutionalization.~~

B. Special provider participation conditions. In order to be a participating provider, the adult day health care center shall:

1. Be an adult day care center licensed by DSS. A copy of the current license shall be available to ~~the~~ DMAS for verification purposes prior to the applicant's enrollment as a Medicaid provider and shall be available for DMAS review; ~~prior to yearly contract renewal.~~

2. Adhere to ~~the~~ DSS adult day care center standards. ~~The~~ DMAS special participation conditions included here are standards imposed in addition to DSS standards which shall be met in order to provide Medicaid adult day health care services~~.~~ ;

3. The center shall ~~be able to~~ provide a separate room or an area equipped with one bed~~, or~~ cot, or recliner for every ~~six~~twelve Medicaid adult day health care participants~~.~~; and

4. Employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each participant.

The following staff are required by DMAS:

a. The ~~adult day health care~~ center shall maintain a minimum staff-to-participant ratio of one staff member to every six participants ~~(Medicaid and other participants)~~. This includes Medicaid and other participants;

b. There shall be at least two staff ~~persons~~ members at the center at all times when there are Medicaid participants in attendance~~.~~ ;

c. In the absence of the director, ~~a professional staff member~~ the Activities Director, Registered Nurse or therapist shall be designated to supervise the program~~.~~ ;

d. Volunteers ~~shall~~ can be included in the staff-to-participant ratio if these volunteers meet the qualifications and training requirements for compensated employees; and, for each volunteer, there shall be at least one compensated employee included in the staff-to-participant ratio; ~~only when they conform to the same standards and requirements as paid staff and meet the job description standards of the organization.~~

e. Any center that is collocated with another facility shall count only its own separate identifiable staff in the center's ~~staff/participant~~ staff-to-participant ratio.

f. The adult day health care center shall employ the following:

(1) A director who shall be responsible for overall management of the center's programs. This individual shall be the provider contact person for DMAS and the designated preauthorization contractor, ~~staff~~ and shall be responsible for ~~contracting, and receipt and response~~ responding to communication from DMAS and the designated preauthorization contractor. The director shall be responsible for assuring the ~~initial~~ development of the ~~Plan of Care~~ plan of care for adult day health care participants. The director has ultimate responsibility for directing the center program and supervision of its employees. The director can also serve as the activities director ~~also~~ if those qualifications are met.

(2) An activities director who shall be responsible for directing recreational and social activities for the adult day health care participants.

(3) Program aides who shall be responsible for overall assistance with care and maintenance of the participant (assistance with activities of daily living, recreational activities, and other health and therapeutic related activities).

g. The ~~adult day health care~~ center shall employ or subcontract with a registered nurse who shall be responsible for administering and monitoring the health needs of the ~~adult day health care~~ participants. The nurse shall be responsible for the planning, organization, and management of ~~a treatment~~ the plan of care involving multiple services where specialized health care knowledge ~~shall be applied~~ is needed. The nurse shall be present a minimum of eight hours ~~one day~~ each month at the ~~adult day health care~~ center. ~~to render direct services to Medicaid adult day health care participants.~~ ~~The~~ DMAS may require the nurse's presence at the adult day health care center for more than this minimum standard depending on the number of participants in attendance and according to the medical and nursing needs of the participants. Although ~~the~~ DMAS does not require that the nurse be a full-time staff position, there shall be a nurse available, either in person or by telephone ~~at a minimum~~, to the center's participants during all times that the center is in operation.

h. The director shall assign ~~a professional staff member~~ himself, the Activities Director, Registered Nurse or therapist to act as adult day health care coordinator for each participant and shall document in the participant's file the identity of the care coordinator. The adult day health care coordinator shall be responsible for management of the participant's plan of care and for its review with the program aides.

C. Minimum qualifications of adult day health care staff. Documentation of all staffs' credentials shall be maintained in the provider agency's personnel ~~file~~ files for review by DMAS staff who are authorized by the agency to review these files.

1. Program aide. Each program aide hired by the provider agency shall be screened to ensure compliance with ~~minimum~~ qualifications ~~as~~ required by DMAS. The aide shall, at a minimum, have the following qualifications:

a. Be able to read and write in English to the degree necessary to perform the tasks expected;

b. Be physically able to do the work~~.~~ ;

c. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of ~~possible~~ abuse, neglect, or exploitation of incapacitated or older adults

and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

d. Have satisfactorily completed an educational curriculum related to the needs of the elderly and disabled. Acceptable curriculum are offered by educational institutions, nursing facilities, and hospitals. Training consistent with DMAS training guidelines may also be given by the center's professional staff. Curriculum titles include: Nurses Aide, Geriatric Nursing Assistant, and Home Health Aide. Documentation of successful completion shall be maintained in the aide's personnel file and be must available for review by ~~the~~ DMAS staff who are authorized by the agency to review these files. ~~Training consistent with DMAS training guidelines may also be given by the center's professional staff.~~ ~~The content of the training shall be approved by DMAS prior to assignment of the aide to a Medicaid participant~~. Prior to assigning a program aide to a participant, the center shall ensure that the aide has satisfactorily completed a training program consistent with DMAS' standards.

2. Registered nurse. The registered nurse shall:

a. Be registered and licensed to practice nursing in the Commonwealth of Virginia~~.~~ ;

b. Have two years of related clinical experience (which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, ~~or~~ nursing facility , or as an LPN)~~.~~ ; and

c. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of ~~possible~~ abuse, ~~or~~ neglect , or exploitation of ~~incompetent or~~ incapacitated or older adults and children ~~individuals~~. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

3. Activities director. The activities director shall:

a. Have a minimum of 48 semester hours or 72 quarter hours of post secondary education from an accredited college or university with a major in recreational therapy, occupational therapy, or a related field such as art, music, or physical education~~.~~ ;

b. Have one year of related experience which may include work in an acute care hospital, rehabilitation hospital, nursing facility, or have completed a course of study including any

prescribed internship in occupational, physical, and recreational therapy or music, dance, art therapy, or physical education~~.~~ ; and

c. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of ~~possible~~ abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

4. Director. The director shall meet the qualifications specified in the DSS standards for adult day care for directors. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

D. Service responsibilities of the adult day health care center and staff duties are:

1. Aide responsibilities. The aide shall be responsible for assisting with activities of daily living, supervising the participant, and assisting with the management of the participant's ~~Plan of Care~~ plan of care.

2. Nursing responsibilities. These services shall include:

a. Periodic evaluation of the nursing needs of each participant;

b. Provision of the indicated nursing care and treatment~~,~~; and

c. Monitoring, recording, and administering of prescribed medications, if no other individual is designated by the individual's physician to administer medications in the ~~adult day care~~ center, or supervising the individual in self-administered medication.

3. Rehabilitation services coordination responsibilities. These services are designed to ensure the participant receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include the coordination and implementation of physical therapy, occupational therapy, and speech-language therapy. Rendering of the specific Rehabilitative Therapy is not included in the ~~ADHC~~ center's fee for service but must be rendered as a separate service by a ~~DMAS approved~~ rehabilitative provider.

~~4. Transportation responsibilities. Every DMAS approved adult day health care center shall provide transportation when needed in emergency situations (i.e., primary caregiver has an accident and cannot transport the participant home) for all Medicaid participants to and from~~

~~their homes. Any adult day health care center which is able to provide participants with transportation routinely to and from the center can be reimbursed by DMAS based on a per trip (to and from the participant's residence) fee. This reimbursement for transportation shall be preauthorized by either the Nursing Home Preadmission Screening Team or DMAS utilization review staff.~~

4~~5~~. Nutrition responsibilities. The ~~adult day health care~~ center shall provide one meal per day, which supplies one-third of the daily nutritional requirements. Special diets and counseling shall be provided to Medicaid participants as necessary.

5~~6~~. Adult day health care coordination. The designated adult day health care coordinator shall coordinate the delivery of the activities as prescribed in the participants' ~~Plans of Care~~ plan of care and keep it updated, record 30-day progress notes, and review the participants' daily ~~logs~~ records each week.

6~~7~~. Recreation and social activities responsibilities. The ~~adult day health care~~ center shall provide planned recreational and social activities suited to the participants' needs and designed to encourage physical exercise, prevent deterioration, and stimulate social interaction.

E. Documentation required. The ~~adult day health care~~ center shall maintain all records of each Medicaid participant. These records shall be reviewed periodically by DMAS staff who are authorized by the agency to review these files. At a minimum, these records shall contain:

1. The Long-~~term care~~ Term Care ~~Information~~ Uniform Assessment Instrument, the Nursing Home Preadmission Screening Authorization, and the Screening Team Service Plan ~~of Care.~~;

2. Interdisciplinary ~~Plan of Care~~ plans of care developed by ~~adult day health care center~~ the center's ~~professional staff~~ director, activities director, registered nurse, or therapist, ~~and~~ the participant; and relevant support persons~~.~~;

3. Documentation of interdisciplinary staff meetings which shall be held at least every three months to reassess each participant and evaluate the adequacy of the adult day health care ~~Plan of Care~~ plan of care and make any necessary revisions~~.~~;

4. At a minimum, 30-day goal oriented progress notes recorded by the individual who is designated as the adult day health care coordinator. If a participant's condition and treatment plan changes more often, progress notes shall be written more frequently than every 30 days~~.~~;

5. The ~~adult day health care~~ center shall obtain a rehabilitative progress report and updated treatment plan from all professional disciplines involved in the participant's care every 30 days (physical therapy, speech therapy, occupational therapy, home health and others)~~.~~;

6. Daily ~~log~~ records of services provided. The daily ~~log~~ record shall contain the specific services delivered by ~~adult day health care~~ center staff. The ~~log~~ record shall also contain the arrival and departure time of the participant and be signed weekly by ~~the participant or representative and an adult day health care center professional staff member~~ the director, activities director, registered nurse, or therapist employed by the center. The daily ~~log~~ record shall be completed on a daily basis, neither before nor after the date of service delivery. At least once a week, a staff member shall chart significant comments regarding care given to the participant. If the staff member writing comments is different from the staff signing the weekly ~~log~~ record, that staff member shall sign the weekly comments. A copy of this record must be given to the participant or representative weekly; and

7. All correspondence to the participant, ~~and to~~ DMAS, and the designated preauthorization contractor.

~~8. All DMAS utilization review forms and plans of care.~~

12VAC30-120-50. Personal care services.

The following requirements govern the provision of personal care services.

A. General. Personal care services may be offered to individuals ~~in their homes~~ as an alternative to ~~more costly~~ institutional care. Personal care may be offered either as the sole home and community-based care service that avoids institutionalization or in conjunction with adult day health care, ~~or~~ respite care, ~~or both~~or PERS. ~~When the individual referred for personal care is already receiving another home and community-based care service, the DMAS utilization review staff shall assess the need for the additional home and community-based care service and authorize the service if it is deemed necessary to avoid institutionalization.~~

Recipients may continue to work or attend post-secondary school, or both, while they receive services under this waiver. The personal care attendant who assists the recipient may accompany that person to work or school or both and may assist the person with personal needs while the individual is at work or school or both. DMAS will also pay for any personal care services that the attendant gives to the enrolled recipient to assist him in getting ready for work or school or both or when he returns home.

DMAS will review the recipient's needs and the complexity of the disability when determining the services that will be provided to the recipient in the workplace or school or both.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) (42 U.S.C. §§ 12131 to 12165) or the Rehabilitation Act of 1973. For example, if the recipient's only need is for assistance during lunch, DMAS would not pay for the attendant to be with the recipient for any hours extending beyond lunch. For a recipient whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the recipient is physically unable to speak or make himself understood even with a communication device, the attendant's services may be necessary for the length of time the recipient is at work or school or both. DMAS will reimburse for the attendant's services unless the attendant is required to assist the recipient for the length of time the recipient is at work or school or both as a part of the ADA or the Rehabilitation Act.

The provider agency must develop an individualized plan of care which addresses the recipient's needs at home, work, and in the community.

DMAS will not pay for the attendant to assist the enrolled recipient with any functions related to the recipient completing his job or school functions or for supervision time during work or school or both.

B. Special provider participation conditions. The personal care provider shall:

~~1. Demonstrate a prior successful health care delivery.~~

1.~~2.~~ Operate from a business office~~.~~ ;

2.~~3.~~ Employ (or subcontract with) and directly supervise a registered nurse ~~(RN)~~ who will provide ongoing supervision of all personal care aides.

a. The registered nurse ~~RN~~ shall be currently licensed to practice in the Commonwealth of Virginia and have at least two years of related clinical nursing experience (which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, ~~or~~ nursing facility, or as a licensed practical nurse (LPN)).

b. The registered nurse shall have a satisfactory work record, as evidenced by two references from prior job experience, including no evidence of abuse, neglect, or exploitation of

incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

~~b~~c. The registered nurse ~~RN~~ supervisor shall make an initial home assessment ~~home~~ visit ~~prior~~ on or before ~~to~~ the start of care for all new recipients admitted to personal care , when a recipient is re-admitted after being discharged from services, or if he is transferred to another provider or ADHC.

~~c~~d. The registered nurse ~~RN~~ supervisor shall make supervisory visits as often as needed , but no fewer visits than provided as follows, to ensure both quality and appropriateness of services.

1. A minimum frequency of these visits is every 30 days~~.~~ for recipients with a cognitive impairment and every 90 days for recipients who do not have a cognitive impairment.
2. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgement, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.
3. The initial home assessment visit by the registered nurse shall be conducted to create the plan of care and assess the recipient's needs. The registered nurse shall return for

a follow-up visit within 30 days after the initial visit to assess the recipient's needs and make a final determination that there is no cognitive impairment. This determination must be documented in the recipient's record by the Registered Nurse. Recipients who are determined to have a cognitive impairment will continue to have supervisory visits every 30 days.

4. If there is no cognitive impairment, the registered nurse may give the recipient or caregiver or both the option of having the supervisory visit every 90 days or any increment in between, not to exceed 90 days. The registered nurse must document in the recipient's record this conversation and the option that was chosen.

5. The provider agency has the responsibility of determining if 30 day registered nurse supervisory visits are appropriate for the recipient. The provider agency may offer the extended registered nurse visits, or the agency may choose to continue the 30 day supervisory visits based on the needs of the individual. The decision must be documented in the recipient's record.

6. If a recipient's personal care aide is supervised by the provider's registered nurse less often than every 30 days and DMAS or the designated preauthorization contractor determines that the recipient's health, safety and/or welfare is in jeopardy, DMAS, or

the designated preauthorization contractor, may require the provider's registered nurse to supervise the personal care aide every 30 days or more frequently than what has been determined by the registered nurse. This will be documented and entered in the recipient's record.

~~d~~e. During visits to the recipient's home, ~~the~~ a registered nurse ~~RN~~ shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the recipient's current functioning status, medical, and social needs. The personal care aide's record shall be reviewed and the recipient's (or family's) satisfaction with the type and amount of service discussed. The registered nurse ~~RN~~ summary shall note:

(1) Whether personal care services continue to be appropriate~~,~~;

(2) Whether the plan is adequate to meet the recipient's needs ~~need~~ or if changes ~~are indicated in the plan~~ need to be made in the plan of care~~,~~;

(3) Any special tasks performed by the aide and the aide's qualifications to perform these tasks~~,~~;

(4) Recipient's satisfaction with the service~~,~~;

(5) Hospitalization or change in the medical condition or functioning status of the recipient~~,~~;

(6) Other services received by the recipient and ~~their~~ the amount~~,~~; and

(7) The presence or absence of the aide in the home during the registered nurse's ~~RN's~~ visit.

~~e~~. f. ~~The~~ A registered nurse shall be available to the personal care aide for conference pertaining to individuals being served by the aide and shall be available to aides by telephone at all times that the aide is providing services to personal care recipients. ~~Any change in the identity of the RN providing coverage shall be reported immediately to DMAS.~~

~~f.~~ g. The registered nurse ~~RN~~ supervisor shall evaluate the aides' performance and the recipient's ~~individual~~ needs to identify any ~~gaps~~ insufficiencies in the aides' abilities to function competently and shall provide training as indicated.

h. If there is a delay in the registered nurses' supervisory visits, because the recipient was unavailable, the reason for the delay must be documented in the recipient's record.

3.~~4.~~ Employ and directly supervise personal care aides who ~~will~~ provide direct care to personal care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with ~~minimum~~ qualifications ~~as~~ required by DMAS. Each aide shall:

a. Be able to read and write in English to the degree necessary to perform the expected tasks.

b. Complete a minimum of 40 hours of training consistent with DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards~~.~~ ;

c. Be physically able to do the work~~.~~ ;

d. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of ~~possible~~ abuse, neglect , or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

e. Not be ~~a member of the recipient's family (e.g., family is defined as~~ : (i) the parents of minor children who are receiving waiver services, (ii) spouses of individuals who are receiving waiver services, or ~~children, siblings, grandparents, and grandchildren~~) legal guardians of the individuals who are receiving waiver services.

f. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members.

~~C. Provider inability to render services and substitution of aides.~~

~~1. When a personal care aide is absent and the agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients. The agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient to another agency. If no other provider agency is available, the provider agency shall notify the recipient or family so they may contact the local health department to request a Nursing Home Preadmission Screening if nursing home placement is desired.~~

~~2. During temporary, short- term lapses in coverage (not to exceed two weeks in duration), all of the following procedure shall apply:~~

~~a. The personal care agency having recipient responsibility shall provide the registered nurse supervision for the substitute aide.~~

~~b. The agency providing the substitute aide shall send to the personal care agency having recipient care responsibility a copy of the aide's signed daily records signed by the recipient.~~

~~c. The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide.~~

~~3. If a provider agency secures a substitute aide, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met, including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.~~

~~D.~~ C. Required documentation ~~in~~ for recipients' records. The provider agency shall maintain all records of each personal care recipient. These records shall be separate from those of non-home and community-based care services, such as companion or home health services. These records

shall be reviewed periodically by the DMAS staff who are authorized by the agency to review these files. At a minimum ~~these records~~ the record shall contain:

1. The most recently updated Long-Term Care Universal Assessment Instrument, the Preadmission Screening Authorization, the ~~Screening Team Plan~~ screening team service plan ~~of Care~~, all provider agency plans of care, and all DMAS-122's~~.~~ ;

~~2. All DMAS utilization review forms and plans of care~~.

~~3.~~ 2. The initial ~~Initial~~ assessment by ~~the~~ a registered nurse ~~RN supervisory nurse~~ completed prior to or on the date that services are initiated~~.~~ ;

~~4~~. 3. Registered Nurses' notes recorded and dated during ~~any~~ significant contacts with the personal care aide and during supervisory visits to the recipient's home~~.~~ ;

~~5~~. 4. All correspondence to the recipient, ~~and to~~ DMAS, and the designated preauthorization contractor~~.~~ ;

~~6~~. 5. Reassessments made during the provision of services~~.~~ ;

~~7~~. 6. Significant contacts ~~Contacts~~ made with family, physicians, DMAS, the designated preauthorization contractor, formal, informal service providers and all professionals ~~concerning the recipient.~~ related to the recipient's Medicaid services or medical care;

~~8~~. 7. All personal care aide records. The personal care aide record shall contain:

a. The specific services delivered to the recipient by the aide and the recipient's responses to this service~~,~~;

b. The aide's daily arrival and departure times~~,~~;

c. The aide's weekly comments or observations about the recipient ~~to include~~ , including observations of the recipient's physical and emotional condition, daily activities, and responses to services rendered~~,~~; and

d. The aide's and recipient's or responsible caregiver's weekly signatures, including the date, to verify that personal care services have been rendered during that week ~~have been rendered.~~ as documented in the record. Employees of the provider cannot sign for the recipient unless he is a family member of the recipient;

Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered. ; and

~~9~~. 8. All recipient progress reports.

~~E. Recipient progress report. The provider is required to submit to DMAS annually for every recipient a recipient progress report, an updated Long-Term Care Assessment and four aide log sheets. This information is used to assess the recipient's ongoing need for Medicaid funded long-term care and appropriateness and adequacy of services rendered.~~

12VAC30-120-55. Personal Emergency Response System (PERS) services.

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

B. Criteria. PERS services are limited to those recipients, ages 14 and older, who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods

of time, and who would otherwise require extensive routine supervision. PERS may only be provided in conjunction with personal care, respite care, or adult day health care.

PERS can be authorized when there is no one else, other than the recipient, in the home who is competent and continuously available to call for help in an emergency. If the recipient's caregiver has a business in the home, such as, but not limited to, a day care center, PERS will only be approved if the recipient is evaluated as being dependent in the categories of "Behavior Pattern" and "Orientation" on the Uniform Assessment Instrument (UAI).

Medication monitoring units must be physician ordered. In order to receive medication monitoring services, a recipient must also receive PERS services.

C. Service units and service limitations.

1. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month rental price, which is set by DMAS. The one time installation of the unit includes installation, account activation, recipient and caregiver instruction. The one time installation shall also include the cost of the removal of the PERS equipment.

2. PERS services must be capable of being activated by a remote wireless device and be connected to the recipient's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, be able to automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the recipient.

In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a registered nurse, a licensed practical nurse, or a licensed pharmacist. The units can be refilled every 14 days.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-20 and 12VAC30-120-30, providers must also meet the following qualifications:

1. A PERS provider is a certified home health or personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring;

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

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

4. The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24-hours of the recipient's notification of a malfunction of the console unit, activating devices, or medication monitoring unit while the original equipment is being repaired;

5. The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line within seven days of the request unless there is appropriate documentation of why this timeframe can not be met. The PERS provider must furnish all supplies necessary to ensure that the system is installed and working properly. The PERS

provider must test the PERS device monthly, or more frequently if needed, to ensure that the device is fully operational;

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

7. A PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS or the recipient. The record must document all of the following:

a. Delivery and installation date of the PERS;

b. Recipient/caregiver signature verifying receipt of the PERS device;

c. Verification by a test that the PERS device is operational, monthly or more frequently if needed;

d. Updated and current recipient responder and contact information, as provided by the recipient or the recipient's care provider; and

e. A case log documenting the recipient's utilization of the system, all contacts, and all communications with the recipient, caregiver, and responders;

8. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals;

9. Standards for PERS Equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring a manual reset by the recipient;

10. A PERS provider must furnish education, data, and ongoing assistance to DMAS and the designated preauthorization contractor to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the recipient, caregiver, and responders in the use of the PERS service;

11. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the recipient's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the recipient resetting the system in the event it cannot get its signal accepted at the response center;

12. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the monitoring agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from recipients' PERS equipment. The monitoring agency's equipment must include the following:

a. A primary receiver and a back-up receiver, which must be independent and interchangeable;

b. A back-up information retrieval system;

c. A clock printer, which must print out the time and date of the emergency signal, the PERS recipient's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

f. A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

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

13. The monitoring agency must maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures;

14. The PERS provider shall document and furnish within 30 days (of the action taken) a written report for each emergency signal which results in action being taken on behalf of the recipient. This excludes test signals or activations made in error. This written report shall be furnished to the personal care provider, the respite care provider, or in cases where the recipient only receives ADHC services, to the ADHC provider;

15. The PERS provider is prohibited from performing any type of direct marketing activities to Medicaid recipients; and

16. The provider must obtain and keep on file a copy of the most recently completed DMAS-122. Until the provider obtains a copy of the DMAS-122, the provider must clearly document efforts to obtain the completed DMAS-122 from the personal care, respite care, or the ADHC provider.

12VAC30-120-60. Respite care services.

These requirements govern the provision of respite care services.

A. General. Respite care services may be offered to individuals in their homes as an alternative to ~~more costly~~ institutional care. Respite care is distinguished from other services in the

continuum of long-term care because it is specifically designed to focus on the need of the unpaid caregiver for temporary relief. Respite care may only be offered to individuals who have a primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. The authorization of respite care is limited to 720 hours per calendar year per recipient. ~~30 24-hour days over a 12-month period.~~ A recipient who transfers to a different provider or is discharged and re-admitted into the E&D waiver within the same calendar year will not receive an additional 720 hours of respite care. DMAS cannot be billed for more than 720 respite care hours in a calendar year for a waiver recipient. Reimbursement shall be made on an hourly basis , not to exceed a total of 720 hours per calendar year, ~~for any amount authorized~~. ~~up to eight hours within a 24-hour period. Any amount over an eight-hour day will be reimbursed on a per diem basis.~~ The option of respite care may be offered either as a secondary home and community-based care service to those individuals who receive either personal care~~,~~ or adult day health care , ~~or~~ as the sole home and community-based care service , or in conjunction with PERS ~~received in lieu of nursing facility placement~~.

B. Special provider participation conditions. To be approved for respite care contracts with DMAS, the respite care provider shall:

~~1. Demonstrate a prior successful health care delivery.~~

1.~~2.~~ Operate from a business office~~.~~ ;

2.~~3.~~ Employ (or subcontract with) and directly supervise a registered nurse ~~(RN)~~ who will provide ongoing supervision of all respite care aides~~.~~ ;

a. The registered nurse ~~RN~~ shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience (which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, ~~or~~ nursing home, or as an LPN).

b. The registered nurse shall have a satisfactory work record, as evidenced by two references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

~~b~~. c. Based on continuing evaluations of the aides' performance and the recipients' individual needs, the registered nurse ~~RN~~ supervisor shall identify any ~~gaps~~ insufficiencies in the aides' abilities to function competently and shall provide training as indicated.

~~c.~~ d. The registered nurse ~~RN~~ supervisor shall make an initial home assessment visit ~~prior to~~ on or before the start of care for any recipient admitted to respite care.

~~d~~. e. ~~The RN~~ A registered nurse shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these visits shall be every 30 days.

(2) When respite care services are not received on a routine basis, but are episodic in nature, ~~the~~ a registered nurse ~~RN~~ shall not be required to conduct a supervisory visit every 30 days. Instead, ~~the nurse supervisor~~ a registered nurse shall conduct the initial home assessment visit with the respite care aide ~~immediately~~ ~~preceding~~ on or before the start of care and make a second home visit ~~within the respite care period~~ during the second respite care visit.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the ~~30-day~~ supervisory visit conducted for personal care services may serve as the registered nurse supervisory ~~RN~~ visit for respite care. However, the registered nurse ~~RN~~ supervisor shall document supervision of respite care separately from the personal care

documentation. For this purpose, the same recipient record can be used with a separate section for respite care documentation.

~~e~~. f. During visits to the recipient's home, the registered nurse ~~RN~~ shall observe, evaluate, and document the adequacy and appropriateness of respite care services with regard to the recipient's current functioning status, medical, and social needs. The respite care aide's record shall be reviewed ~~and~~ along with the recipient's or family's satisfaction with the type and amount of service discussed. The registered nurse ~~RN~~ shall document in a summary note:

(1) Whether respite care services continue to be appropriate~~,~~;

(2) Whether the plan of care is adequate to meet the recipient's needs or if changes need to be made~~,~~ to the plan of care;

(3) The recipient's satisfaction with the service~~,~~;

(4) Any hospitalization or change in the medical condition or functioning status~~,~~ of the recipient;

(5) Other services received by the recipient and ~~their~~ the amount of the services received ~~,~~; and

(6) The presence or absence of the aide in the home during the registered nurse's visit.

~~f.~~ g. ~~In all cases, the RN shall be available to the respite care aide to discuss the recipient's being served by the aide~~. A registered nurse shall be available to the respite care aide for conference pertaining to individuals being served by the aide and shall be available to aides by telephone at all times that aides are providing services to respite care recipients.

~~g.~~ h. ~~The RN providing supervision to respite care aides shall be available to them by telephone at all times that services are being provided to respite care recipients. Any lapse in RN coverage shall be reported immediately to DMAS~~. If there is a delay in the registered nurse's supervisory visits, because the recipient is unavailable, the reason for the delay must be documented in the recipient's record;

~~4.~~ 3. Employ and directly supervise respite care aides who provide direct care to respite care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with ~~minimum~~ qualifications as required by DMAS. Each aide must:

a. Be able to read and write in English to the degree necessary to perform the tasks expected.

b. Have completed a minimum of 40 hours of training consistent with DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards.;

c. Be evaluated in his job performance by the registered nurse RN supervisor.;

d. Have the physical ability to do the work. Be physically able to do the work;

e. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse , or neglect , or exploitation of incapacitated or older adults and children. of incompetent and/or incapacitated individuals. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record checks shall be available for review by DMAS staff who are authorized by the agency to review these files.

f. Not be a member of a recipient's family (e.g., family is defined as parents, spouses, siblings, grandparents, and grandchildren). Not be: (i) the parents of minor children who are receiving waiver services, (ii) the spouses of individuals receiving waiver services, or (iii) legal guardians of individuals who are receiving waiver services.

g. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members.

4.~~5.~~ The Respite Care Agency may employ a licensed ~~practice~~ practical nurse to ~~deliver~~ perform respite care services, which shall be reimbursed by DMAS under the following circumstances:

a. The licensed practical nurse (LPN) shall be currently licensed to practice in the Commonwealth. The LPN must have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers shall be responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record checks shall be available for review by DMAS staff who are authorized by the agency to review these files;

~~a~~b. The ~~individual receiving care~~ recipient has a need for routine skilled care which cannot be provided by unlicensed personnel. These individuals would typically require a skilled level of care if in a nursing facility (i.e., recipients on a ventilator, recipients requiring nasogastric, or gastrostomy feedings, etc.)~~.~~ ;

~~b~~c. No other individual in the recipient's support system is able to supply the skilled component of the recipient's care during the caregiver's absence~~.~~ ;

~~c~~d. The recipient is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver~~, unless such skilled nursing visits would be more costly than the respite care requested.~~ ; and

~~d~~e. The agency ~~can~~ must document in the recipient's record, the circumstances which require the provision of services by an LPN.

~~C. Inability to provide services and substitution of aides. When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients.~~

~~1. If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient's care to another agency.~~

~~2. If no other provider agency is available who can supply an aide, the provider agency shall notify the recipient or family so that they may contact the local health department to request a Nursing Home Preadmission Screening if nursing home placement is desired.~~

~~3. During temporary, short- term lapses in coverage, which shall not exceed two weeks in duration, a substitute aide may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following procedures apply:~~

~~a. The respite care agency having recipient responsibility shall be responsible for providing the RN supervision for the substitute aide;~~

~~b. The agency providing the substitute aide shall send to the respite care agency having recipient care responsibility a copy of the aide's daily records signed by the recipient and the substitute aide. All documentation of services rendered by the substitute aide shall be in the recipient's record. The documentation of the substitute aide's qualifications shall also be obtained and recorded in the personnel files of the agency having recipient care responsibility~~

~~c. The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide. The two agencies involved shall negotiate the financial arrangements of paying the substitute aide.~~

~~4. Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for recipient respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case shall be transferred to another respite care provider agency that has the aide capability to serve the recipient(s).~~

~~5. If a provider agency secures a substitute aide it is the responsibility of the provider agency having recipient care responsibility to ensure that all DMAS requirements continue to be met, including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.~~

~~D.~~ C. Required documentation for ~~recipients~~ recipients' records. The provider agency shall maintain all records of each respite care recipient. These records shall be separated from those of ~~other~~ non-home and community-based care services, such as companion ~~services~~ or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by the agency to review these files. At a minimum these records shall contain:

1. The most recently updated Long-Term Care Universal Assessment Instrument, the Nursing Home Preadmission Screening Authorization, the screening team service plan, all ~~Respite Care Assessment and Plans of Care~~ respite care assessment and plans of care, and all DMAS-122's.~~.~~;

~~2. All DMAS utilization review forms and plans of care.~~

~~3~~. 2. ~~Initial~~ The initial assessment by ~~the~~ a registered nurse ~~RN supervisory nurse~~ completed prior to or on the date services are initiated.~~.~~;

~~4~~ 3. Registered nurse's notes recorded and dated during significant contacts with the respite care aide and during supervisory visits to the recipient's home.~~.~~;

~~5~~. 4. All correspondence to the recipient, ~~and to~~ DMAS, and the designated preauthorization contractor.~~.~~;

~~6~~. 5. Reassessments made during the provision of services.~~.~~;

~~7~~. 6. Significant contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal service providers, and all professionals ~~concerning the recipient .~~ related to the recipient's Medicaid services or medical care; and

~~8.~~ 7. ~~Respite~~ All respite care aide records ~~record of services rendered and recipient's responses~~. The respite care aide record shall contain:

a. The specific services delivered to the recipient by the respite care aide or LPN, and the recipient's response~~,~~ to this service;

b. The daily arrival and departure ~~time~~ times of the aide or LPN for respite care services ~~only,~~;

c. Comments or observations recorded weekly about the recipient. Aide or LPN comments shall include but not be limited to observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered~~,~~; and

d. The ~~signature by~~ signatures of the aide or LPN, and the recipient , once each week to verify that respite care services have been rendered. Signature, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered. If the recipient is unable to sign the aide record, it must be documented in the recipient's record how or who will sign in his place. Employees of the provider shall not sign for the recipient unless he is a family member of the recipient.

8. All recipient progress reports.

~~9. Copies of all aide records shall be subject to review by state and federal Medicaid representatives.~~

~~10. If a respite care recipient is also receiving any other service (meals on wheels, companion, home health services, etc.) the respite care record shall indicate that these services are also being received by the recipient.~~

~~E. Authorization of combined services. Respite care, when offered in conjunction with another home and community-based care service, is considered by DMAS a secondary home and community-based care service necessary for the recipients' continued maintenance in the community. Respite care is only available to caregivers as an adjunct to another primary home and community-based care service under the following conditions:~~

~~1. The individual has been authorized to receive a primary home and community-based care service by the Nursing Home Preadmission Screening Team and such care has been initiated.~~

~~2. The primary home and community-based care services offered to the individual are determined to be insufficient to prevent the breakdown of the caregiver due to the physical~~

~~burden and emotional stress of providing continuous support and care to the dependent individual.~~

~~F Provider responsibility. The provider of the primary home and community-based care service shall contact the DMAS utilization review staff when the need for respite care as a secondary home and community-based care service has been identified according to the criteria above. DMAS shall conduct an assessment of the individual caregiver's need for respite care and, if appropriate, authorize respite care.~~

CERTIFIED:

___05/28/02_____ _/s/ Patrick W. Finnerty_____

Date Patrick W. Finnerty, Director

Dept. of Medical Assistance Services