12VAC30-120-140. 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.).~~

"Acquired Immune Deficiency Syndrome" or "AIDS" means the most severe manifestation of infection with the Human Immunodeficiency Virus (HIV). The Centers for Disease Control and Prevention (CDC) lists numerous opportunistic infections and cancers that, in the presence of HIV infection, constitute an AIDS diagnosis.

~~"Acquired immunodeficiency syndrome (AIDS)" means the set of symptoms related to specific opportunistic diseases indicative of an immune deficiency state in the absence of any other cause of reduced resistance reported to be associated with at least one of those opportunistic diseases. Individuals diagnosed with AIDS may experience symptoms associated with severe dementia, HIV encephalopathy, HIV wasting syndrome and rare forms of pneumonia (pneumocystic carinii (PCP)) and cancer (Kaposi's Sarcoma (KS)).~~

"Activities of daily living" or "ADL" means personal care tasks, i.e., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"AIDS-Related Complex" or ~~("~~"ARC~~))~~" means the lesser disease response to the HIV infection which may, nonetheless, have many of the devastating effects of the AIDS virus, but not the specific conditions used to define a case of AIDS. This term shall be applied to those individuals with HIV infection experiencing symptoms related to the infection.

"~~Aids~~AIDS Service Organizations" or ~~(~~"ASOs)" means the regional and local service organizations developed to provide education, prevention, and health and social services to individuals infected with the HIV virus.

"Asymptomatic" means without symptoms. This term is usually used in the HIV/AIDS literature to describe an individual who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.

"Case management" means continuous reevaluation of need, monitoring of service delivery, revisions to the ~~Plan of Care~~ plan of care and coordination of services for AIDS individuals receiving home and community-based services in order to assure effective and efficient delivery of direct services.

"Case manager" means the professional person who provides services to recipients which enables the continuous assessment, coordination, and monitoring of the needs of the individuals diagnosed with AIDS or ARC throughout the term of the individuals' receipt of waiver services. The case manager must possess a combination of work experience and relevant education that indicates that the case manager possesses the knowledge, skills, and abilities at entry level, as established by the Department of Medical Assistance Services in 12VAC30-120-160.

"Cognitive impairment" means a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, 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.

"Consumer-directed services" means services for which the recipient or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

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

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

"DMAS" means the Department of Medical Assistance Services.

"DMAS-122 form" means the Patient Information Form, which is used by the provider and the local DSS to exchange information regarding the responsibility of a Medicaid-eligible recipient to make payment toward the cost of services or other information that may affect the eligibility status of a recipient.

"DSS" means the Department of Social Services.

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

~~"Episodic respite care" means in-home services specifically designed to provide relief to the caregiver for a non-routine, short-term period of time for a specified reason (e.g., respite care offered for 7 days, 24 hours a day while the caregiver takes a vacation).~~

"Fiscal agent" means an agency or organization that may be contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of the recipient who is

receiving consumer-directed personal assistance services and consumer-directed respite services.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS (case management, personal care, skilled nursing, respite care, and nutritional supplements) authorized under a Social Security Act §1915(c) AIDS Waiver designed to offer individuals an alternative to hospital or nursing facility ~~care~~placement. 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 ~~service(s)~~ services in order to avoid nursing facility or inpatient hospital placement. An individual may only receive home and community-based services up to the amount which would be equal to or less than the cost of hospital or nursing facility care. The Nursing Home preadmission screening team, ~~or~~ DMAS, or the designated preauthorization contractor shall give prior authorization for any Medicaid-reimbursed home and community-based care.

"Human Immunodeficiency Virus" or ~~(~~"HIV~~)~~" means the virus which leads to acquired immune deficiency syndrome (AIDS). The virus weakens the body's immune system and, in doing so, allows "opportunistic" infections and diseases to attack the body.

"Instrumental activities of daily living" or "IADL" means social tasks, i.e., meal preparation, shopping, housekeeping, laundry, and money management. An individual's degree of independence in performing these activities is part of determining appropriate level of care and services. Meal preparation is planning, preparing, cooking, and serving food. Shopping is getting to and from the store, obtaining and paying for groceries, and carrying them home. Housekeeping is dusting, washing dishes, making beds, vacuuming, cleaning floors, and cleaning the bathroom and kitchen. Laundry is washing and drying clothes. Money management is paying bills, writing checks, handling cash transactions, and making change.

"Nursing Home Preadmission Screening" or "NHPAS" means the process to (i) evaluate the functional, nursing, and social 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 facility or community-based care for those individuals who meet nursing facility level of care.

"Nursing Home Preadmission Screening Committee/Team" or "NHPAS Committee" or "NHPAS Team" means the entity contracted with DMAS that is responsible for performing nursing home preadmission screening. For individuals in the community, this entity is a committee comprised of 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 and an acute care team.

"Nutritional supplements" means nonlegend drug nutritional supplements covered under this waiver which are deemed by a physician to be necessary as the primary source of nutrition for the AIDS/ARC recipient's ~~individual's~~ health care plan (due to the prevalence of conditions of wasting, malnutrition and dehydration) and not available through any other food program.

~~"Preadmission screening" means the process to: (i) evaluate the medical, nursing, and social needs of individuals referred for prescreening, (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 community-based care for those individuals who meet hospital or nursing facility level of care and require such care.~~

~~"Preadmission screening team" means the multidisciplinary team contracted with DMAS to perform preadmission screening. DMAS will contract with regional and local AIDS Service Organizations (ASO) to perform the prescreening assessment, level of care determination and Plan of Care development for Medicaid-eligible individuals with AIDS/ARC. Preadmission screening teams for individuals with AIDS/ARC may also be the nursing home preadmission screening teams contracted with DMAS to perform preadmission screening for Medicaid-eligible individuals at risk of placement in a nursing facility. At a minimum, the preadmission screening team must be comprised of the recipient, nursing and social work staff and a physician.~~

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

"Personal assistant" means a person who provides personal assistance services.

"Personal assistance services" or "PAS" means assistance with Activities of Daily Living, Instrumental Activities of Daily Living, access to the community, monitoring of self-administration of medication or other medical needs, and the monitoring of health status and physical condition.

~~"Program" means medical assistance services as administered by the Department of Medical Assistance Services.~~

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

~~"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 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 ~~of services 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.~~ for the delivery of home and community-based care developed by the provider and related solely to the specific services required by the recipient to ensure his optimal health and safety.

"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

"Program" means the Virginia Medicaid program as administered by the Department of Medical Assistance Services.

"Respite care" means ~~in-home~~ services specifically designed to provide a temporary, but periodic or routine relief, to the primary unpaid caregiver of ~~an individual~~ a recipient who is incapacitated or dependent due to AIDS or ARC. 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 that renders services designed to prevent or reduce inappropriate institutional care by providing eligible recipients with respite care aides who provide respite care services.

~~"Routine respite care" means in-home services specifically designed to provide relief from continuous care to the caregiver on a periodic basis over an extended period of time (i.e., respite care offered regularly one day a week for six hours).~~

"Service facilitation provider" means the provider contracted by DMAS that is responsible for ensuring that the assessment, development, and monitoring of the plan of care, management training, and review activities as required by DMAS are accomplished. Individuals employed by the service facilitation provider shall meet the knowledge, skills, and abilities as further defined in this part.

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

"Skilled nursing" means professional nursing care provided by a registered nurse or licensed practical nurse in the individual's home or other community setting that is ~~and~~ necessary to avoid institutionalization of the individual with AIDS. This service includes

~~by~~ assessment and monitoring of the medical condition, providing interventions, and communicating with the physician regarding changes in the patient's status.

"State Plan for Medical Assistance" or "the Plan" or "the State 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.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire, which assesses an individual's social, physical health, mental health, and functional abilities. The UAI is used to gather information for the determination of an individual's care needs and service eligibility, and for planning and monitoring an individual's care across various agencies for long-term care services.

~~12VAC30-120-150~~. 12 VAC 30-120-145. General coverage and requirements for home and community-based care services for individuals with ~~AIDS~~ HIV/AIDS.

A. Coverage statement.

1. Coverage shall be provided under the administration of the Department of Medical Assistance Services for individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS or ARC, who would otherwise require the level of care provided in a hospital or nursing facility.

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

B. Patient eligibility requirements.

1. DMAS 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.

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. The medically needy individuals participating in the waiver will also be considered as if they were institutionalized for the purpose of applying the institutional deeming rules.

2. Virginia will reduce its payment for home and community-based service 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 services provided to an individual eligible for home and community-based waiver services by the amount that remains after deducting the following amounts in the following order from the individual's income:

a. For individuals to whom §1924(d) applies:

(1) An amount for the maintenance needs of the individual which is equal to 300% of the categorically needy income standard for a noninstitutionalized individual.

(2) For an individual with only a spouse living at home, the community spousal income allowance determined in accordance with §1924(d) of the Social Security Act, the same as that applied for the institutionalized patient.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with §1924(d) of the Social Security Act, the same as that applied for the institutionalized patient.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

(a) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) Necessary medical or remedial care recognized under state law, but not covered under the state's Medicaid Plan.

b. For all other individuals:

(1) An amount for the maintenance needs of the individual which is equal to 300% of the categorically needy income standard for a noninstitutionalized individual.

(2) 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.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

(a) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) Necessary medical or remedial care recognized under state law, but not covered under the state's Medicaid Plan.

C. Assessment and authorization of home and community-based care services for individuals with AIDS/ARC.

1. The individual's status as an AIDS/ARC individual in need of home and community-based care services shall be determined by the preadmission screening team after completion of a thorough assessment of the individual's needs and available support. Screening by the preadmission screening team and preauthorization of home and community-based care services by DMAS ~~staff~~ , or the designated preauthorization contractor is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

2. An essential part of the preadmission screening team's assessment process is determining the level of care required by applying existing criteria for hospital or nursing facility care according to the Virginia Medicaid Hospital Criteria or the Virginia Medicaid Nursing Facility Criteria.

3. The team shall explore alternative settings and/or services to provide the care needed by the individual. If hospital placement or a combination of other services are 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 hospital or nursing facility placement, the screening team shall develop an appropriate Plan of Care, compute cost-effectiveness and make a recommendation for waiver services.

4. Virginia's home and community-based care services for individuals with AIDS/ARC may only be recommended by the preadmission screening team if:

a. The physician who is part of the designated preadmission screening team specifically states the individual has a diagnosis of AIDS or ARC,

b. The preadmission screening team can document that the individual is experiencing medical and functional symptoms associated with AIDS or ARC which would, in the absence of waiver services, require the level of care provided in a hospital, or nursing facility, the cost of which would be reimbursed under the State Medicaid Plan,

c. The individual requesting waiver services is not an inpatient of a nursing facility or hospital,

d. Waiver services can reasonably be expected to cost equal to or less than institutional services and ensure the individual's safety and welfare in the home and community.

5. The preadmission screening team must submit all preadmission screening information and a recommendation to DMAS for final determination of level of care and authorization for home and community-based care services. DMAS or the designated preauthorization contractor authorization must be obtained prior to referral and Medicaid reimbursement for waiver services.

~~12VAC30-120-160~~. 12 VAC 30-120-150 General conditions and requirements for all participating providers for home and community-based services for individuals with AIDS/ARC.

All providers must meet the general requirements and conditions for provider participation. In addition, there are specific requirements for each of the service providers (case management, personal care, respite care ~~and~~ , ~~skilled~~ private duty nursing, nutritional supplements, consumer-directed personal assistance services, and consumer-directed respite care services) which are set forth in ~~12VAC30-120-170~~ 12VAC30-120-160 through 12VAC30-120-200.

A. General requirements. All 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.

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

3. Assure the recipient has 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 §504 of the Rehabilitation Act of 1973 which prohibits 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 provider 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 as defined in the provider manuals shall be met:

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 and in the applicable DMAS provider service manual.

E. Recipient choice of provider agencies. If there is more than one approved provider agency in the community, the individual will have the option of selecting the provider agency of his choice.

F. Termination of provider participation. DMAS may administratively terminate a provider from participation upon 60 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. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

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

1. The reconsideration process shall consist of three phases:

a. A written response and reconsideration to the preliminary findings.

b. An informal conference.

c. A formal evidentiary hearing.

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

3. An appeal of adverse actions shall be heard in accordance with the Administrative Process Act (~~§9-6.14:1~~ 2.2-4000 et seq. of the Code of Virginia) and the State Plan. Judicial review of the final agency determination shall be made in accordance with the Administrative Process Act.

H. Participating provider agency's responsibility for the Recipient Information Form (DMAS-122). It is the responsibility of the provider agency to notify DMAS 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.

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. Agencies providing direct service are responsible for revisions to their individual service plan but must have any change which increases the amount of service or any change not agreed to by the recipient authorized by the case manager (refer to ~~12VAC30-120-170~~ 12VAC30-120-160).

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

a. The provider agency may decrease the amount of authorized care only if the recipient agrees with the provider that a decrease in care is needed and that the amount of care in the revised Plan of Care is appropriate.

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

c. The provider shall discuss the decrease in care with the recipient and/or family, document the conversation in the recipient's record, and shall notify the recipient or family and the recipient's case manager of the change by letter. The participating provider shall give the recipient and/or family 10 days written notification of the intent to decrease services. The letter shall provide the reasons for and effective date of the decrease. The effective date of the decrease in service shall be at least five days from the date of the decrease notification letter.

d. If the recipient disagrees with the decrease proposed, the provider shall contact the case manager to review the recipient's service needs and authorize the needed level of service.

2. Increases in amount of authorized care. If a change in the recipient's condition (physical, mental, or social) necessitates an increase in care, the provider shall develop a Plan of Care for services to meet the changed needs and contact the case manager assigned to the recipient who will, if appropriate, authorize the increase in service. The

provider may implement the increase in hours once approval from the case manager is obtained.

3. Nonemergency termination of home and community-based care services by the provider. The provider shall give the recipient and/or family five days' written notification of the intent to terminate services. The letter shall provide the reasons for and effective date of the termination. The effective date of services termination 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 must be notified prior to termination. The five-day written notification period shall not be required.

5. Termination of home and community-based care services for a recipient by the case manager. The effective date of termination shall be at least 10 days from the date of the termination notification letter. The case manager has the responsibility and the authority to terminate home and community-based care services to the recipient for any of these reasons:

a. Home and community-based care services are no longer 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.

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 shall report this to the local DSS.

K. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of 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 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.

12VAC30-120-155. Consumer-directed services: personal assistance and respite care services.

A. Service definition.

1. Consumer-directed personal assistance services is hands-on care of either a supportive or health-related nature and may include, but is not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medication or other medical needs, monitoring health status and physical condition, and work-related personal assistance. When specified, such supportive services may include assistance with instrumental activities of daily living (IADLs). Personal assistance does 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 Subtitle III of Title 54.1 of the Code of Virginia, as appropriate.

2. Consumer-directed respite care services are specifically designed to provide temporary, periodic, or routine relief to the unpaid primary caregiver of an individual. Respite services include, but are not limited to, assistance with personal hygiene, nutritional support, and environmental support. This service may be provided in the individual's home or other community settings.

3. DMAS shall either provide for fiscal agent services or contract for the services of a fiscal agent for consumer-directed personal assistance services and consumer-directed respite care services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

4. Individuals choosing consumer-directed services must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance services, or respite care services. The CD Service Facilitator will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the plan of care, providing training to the individual and family/caregiver on his responsibilities as an employer, and providing ongoing support of the consumer-directed services. The CD service facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the assistant.

B. Criteria.

1. In order to qualify for consumer-directed personal assistance services, the individual must demonstrate a need for personal assistance in activities of daily living, community access, self-administration of medication, or other medical needs, or monitoring health status or physical condition.

2. Consumer-directed respite care services may only be offered to individuals who have an unpaid caregiver living in the home that requires temporary relief to avoid institutionalization of the individual. Respite services are designed to focus on the need of the unpaid caregiver for temporary relief and to help prevent the breakdown of the unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual.

3. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal assistants and supervise the assistant's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

4. The individual, or if the individual is unable, then a family/caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing assistants. Specific employer duties include checking of references of personal assistants, determining that personal assistants meet basic qualifications, training assistants, supervising the assistant's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or family/caregiver must have a back-up plan in case the assistant does not show up for work as expected or terminates employment without prior notice.

C. Service units and service limitations.

1. The unit of service for consumer-directed respite services is one hour. Consumer-directed respite services are limited to a maximum of 720 hours per calendar year. Individuals who receive consumer-directed respite care and agency-directed respite care services may not receive more than 720 hours combined.

2. No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the assistant.

3. There shall be a limit of eight hours per 24-hour day for consumer-directed services, whether it is a standalone service or is combined with agency-directed services.

4. The unit of service for consumer-directed personal assistance services is one hour. Each individual must have a back-up plan in case the assistant does not show up for work as expected or terminates employment without prior notice.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12 VAC 30-120-145 and 12 VAC 30-120-150, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human services field working with persons with HIV/AIDS. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:
(1) Types of functional limitations and health problems that may occur in persons with HIV/AIDS, as well as strategies to reduce limitations and health problems;
(2) Physical assistance that may be required by persons with HIV/AIDS, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
(3) Equipment and environmental modifications that may be required by persons with HIV/AIDS that reduces the need for human help and improve safety;
(4) Various long term care program requirements, including nursing facility and assisted living facility placement criteria, Medicaid waiver services, and other federal, state and local resources that provide personal assistance and respite care services;
(5) DMAS HIV/AIDS waiver requirements, as well as the administrative duties for which the recipient will be responsible;
(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;
(7) Interviewing techniques;
(8) The recipient's right to make decisions about, direct the provisions of, and control his CD personal assistance and respite services, including hiring, training, managing, approving time sheets, and firing an assistant;
(9) The principles of human behavior and interpersonal relationships; and
(10) General principles of record documentation;

b. Skills in:
(1) Negotiating with recipients and service providers;
(2) Assessing, supporting, observing, recording, and reporting behaviors;
(3) Identifying, developing, or providing services to recipients with HIV/AIDS, and

(4) Identifying services within the established services system to meet the recipient's needs.

c. Abilities to:
(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for recipients who have visual impairments;
(2) Demonstrate a positive regard for recipients and their families;
(3) Be persistent and remain objective;
(4) Work independently, performing position duties under general supervision;
(5) Communicate effectively, verbally and in writing; and
(6) Develop a rapport and communicate with different types of recipients from diverse cultural backgrounds.

3. If the CD services facilitator is not a registered nurse, the service facilitator must contact the primary health care provider to inform them that services are being provided and to request consultation as needed.

4. Initiation of services and service monitoring.
a. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and family/caregiver to identify the needs, assist in the development of the plan of care with the individual or family/caregiver, and provide employee management training. The initial comprehensive home visit is done only once upon the individual's entry into the service. If a waiver individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.
b. After the initial visit, the CD services facilitator will continue to monitor the assistant's plan of care quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 300 respite services hours, whichever comes first.
c. A face-to-face meeting with the individual must be conducted at least every six months to ensure appropriateness of any CD services received by the individual.

5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical, and social needs. The CD services facilitator's written summary of the visit must include, but is not necessarily limited to:
a. Discussion with the individual or family/caregiver whether the service is adequate to meet the individual's needs;
b. Any suspected abuse, neglect, or exploitation and who it was reported to;
c. Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;
d. Individual's or family/caregiver's satisfaction with the service;
e. Any hospitalization or change in medical condition, functioning, or cognitive status;

and
f. The presence or absence of the assistant in the home during the CD services facilitator's visit.

6. The CD services facilitator must be available to the individual by telephone.

7. The CD services facilitator must submit a criminal record check pertaining to the assistant on behalf of the individual and report findings of the criminal record check to the individual or the family/caregiver and the program's fiscal agent. If the individual is a minor, the assistant must also be screened through the DSS Child Protective Services Central Registry. Assistants will not be reimbursed for services provided to the individual on or after the date that the criminal record check confirms an assistant has been found to have been convicted of a crime as described in § 37.1-183.3 of the Code of Virginia or on or after the date the DSS Child Protective Services Registry has a confirmed record. The criminal record check and in the case of a minor recipient a DSS Child Protective Services Registry finding must be requested by the CD services facilitator prior to beginning CD services.

8. The CD services facilitator shall review timesheets during the face-to-face visits to ensure that the number of plan of care-approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual to resolve discrepancies and must notify the fiscal agent.

9. The CD services facilitator must maintain a list of persons who are available to provide consumer-directed personal assistance or consumer-directed respite services.

10. The CD services facilitator must maintain records of each individual. At a minimum these records must contain:

a. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation. For consumer directed respite care, the CD services facilitator must make an initial comprehensive home visit to collaborate with the recipient and family/caregiver to identify the needs, assist with the development of the plan of care with the recipient or family/caregiver, and provide employee management training. The initial comprehensive home visit is done only once upon the recipient's initial entry into the service. After the initial visit, the CD services facilitator will review the utilization of consumer-directed respite care services either every six months or upon the use of 300 respite service hours, whichever comes first. If a recipient changes CD services facilitators, the new CD services facilitator must bill for a reassessment in lieu of a comprehensive visit.
b. The plan of care goals and activities must be reviewed at least annually by the CD services facilitator, the recipient and family/caregiver receiving the services, and the case

manager. In addition, the plan of care must be reviewed by the CD services facilitator quarterly, modified as appropriate, and submitted to the case manager;

c. CD service facilitator's dated notes documenting any contacts with the recipient, family/caregiver, and visits to the recipient's home;

d. All correspondence to the recipient, case manager, the designated preauthorization contractor, and DMAS.

e. Records of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the recipient;

f. All training provided to the assistants on behalf of the recipient or family/caregiver;

g. All employee management training provided to the recipient or family/caregiver, including the recipient's or family/caregiver's receipt of training on their responsibility for the accuracy of the assistant's timesheets;

h. All documents signed by the recipient or the recipient's family/caregiver that acknowledge the responsibilities as the employer; and

i. The facilitator must clearly document efforts to obtain the most recently completed DMAS-122 from the case manager.

11. For consumer-directed personal assistance and consumer-directed respite services, individuals or family/caregivers will hire their own personal assistants and manage and supervise their performance. The assistant must meet the following requirements:

a. Be 18 years of age or older;

b. Have the required skills to perform consumer-directed services as specified in the individual's plan of care;

c. Possess basic math, reading, and writing skills;

d. Possess a valid Social Security number;

e. Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The assistant will not be compensated for services provided to the individual if either of these records checks verifies the assistant has been convicted of crimes described in § 37.1-183.3 of the *Code of Virginia* or if the assistant/companion has a founded complaint confirmed by the DSS Child Protective Services Central Registry;

f. Be willing to attend training at the individual's or family/ caregiver's request;

g. Understand and agree to comply with the DMAS AIDS waiver requirements; and

h. Receive periodic tuberculosis (TB) screening, cardiopulmonary resuscitation (CPR) training and an annual flu shot (unless medically contraindicated).

12. Assistants may not be the parents of individuals who are minors or the individuals' spouses. Payment may not be made for services furnished by other family/caregivers living under the same roof as the individual being served unless there is objective written documentation as to why there are no other providers available to provide the care.

13. Family members who are reimbursed to provide consumer-directed services must meet the assistant qualifications.

14. Should the recipient's assistant not be available for work and upon the recipient's request, the CD services facilitator shall provide the recipient or family/caregiver with a

list of persons who can provide temporary assistance until the assistant returns or the recipient is able to select and hire a new personal assistant. If a recipient is consistently unable to hire and retain the employment of an assistant to provide consumer-directed personal assistance or respite services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the recipient or family/caregiver other service options.

E. Recipient responsibilities.

1. The recipient shall cooperate with the development of the plan of care with the service facilitation provider, who monitors the plan of care and provides supportive services to the recipient. The recipient shall also cooperate with the fiscal agent that handles fiscal responsibilities on behalf of the recipient. Recipients who do not cooperate with the service facilitation provider and fiscal agent will be disenrolled from consumer-directed services and enrolled in agency-directed services.

2. Recipients will acknowledge that they will not knowingly continue to accept consumer-directed personal assistance services when the services are no longer appropriate or necessary for their care needs and will inform the service facilitation provider.

3. The recipient's right to make decisions about, direct the provisions of, and control his assistance care and consumer-directed respite care services, including hiring, training, managing, approving time sheets, and firing an assistant shall be preserved.

F. Service facilitation provider duties.

1. The CD service facilitator must make an initial, comprehensive home visit to develop the recipient's plan of care with the recipient or family/caregiver and provide employee management training. Recipients or family/caregivers who cannot receive management training at the time of the initial visit must receive management training within seven days of the initial visit. After the initial visit, two routine onsite visits must occur in the recipient's home within 60 days of the initiation of care or the initial visit to monitor the plan of care. The CD service facilitator will continue to monitor the plan of care on an as needed basis, not to exceed a maximum of one routine onsite visit every 30 days but no less than the minimum of one routine onsite visit every six months per recipient. The initial comprehensive visit is performed only once upon the recipient's entry into the program. If a waiver recipient changes CD service facilitation provider agencies, the new CD service facilitator shall bill for a reassessment in lieu of a comprehensive visit. After the first two routine onsite visits, the CD services facilitator and recipient can decide on the frequency of the routine onsite visits. However, a face-to-face meeting with the recipient must be conducted at least every six months to ensure appropriateness of services.

2. A reevaluation of the recipient's level of care will occur six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months. During visits to the recipient's home, the CD service facilitator shall observe, evaluate, consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the recipient's current functioning and cognitive status, medical, and social needs. The CD service facilitator shall discuss the recipient's satisfaction with the type and amount of service. The CD service facilitator's written summary of the visit shall include, but is not necessarily limited to:

a. Whether consumer-directed services continue to be appropriate and medically necessary to prevent institutionalization;

b. Whether the plan of care is adequate to meet the needs of the recipient;

c. Any suspected abuse, neglect, or exploitation and to whom it was reported;

d. Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;

e. The recipient's or family/caregiver's satisfaction with the service;

f. Any hospitalization or change in medical condition, functioning, or cognitive status;

g. Other services received and their amount; and

h. The presence or absence of the assistant in the home during the service facilitator's visit.

3. The CD service facilitator shall be available to the recipient by telephone.

4. The CD service facilitator shall maintain a personal assistant registry. The registry shall contain names of persons who have experience with providing personal assistance services or who are interested in providing personal assistance services. The registry shall be maintained as a supportive source for the recipient who may use the registry to obtain the names of potential personal assistants. The CD service facilitation provider shall note on the plan of care what constitutes the recipient's back-up plan in case the personal assistant does not report for work as expected or terminates employment without prior notice. Upon the recipient's request, the CD service facilitation provider shall provide the recipient with a list of persons on the personal assistant registry who can provide temporary assistance until the assistant returns or the recipient is able to select and hire a new personal assistant. If a recipient is consistently unable to hire and retain the employment of an assistant to provide personal assistance services, the CD service facilitation provider must:

a. Contact DMAS or the designated preauthorization contractor to transfer the recipient to a provider that provides Medicaid-funded agency-directed personal care services. The CD service facilitation provider will make arrangements to have the recipient transferred, or

b. Contact the local health department and request a Nursing Home Preadmission Screening to determine if another long-term care option is appropriate.

5. The consumer-directed service facilitation provider must maintain all records of each consumer-directed services recipient. At a minimum these records shall contain:

a. All copies of the completed Uniform Assessment Instrument (UAI), the Long-Term Care Preadmission Screening Authorization (DMAS-96), the Screening Team Service Plan (DMAS-97), the Consent to Exchange Information (DMAS-20), all plans of care, and all DMAS-122's.

b. The consumer-directed service facilitation provider's notes recorded and dated during any contacts with the recipient and during visits to the recipient's home.

c. All correspondence to the recipient and to DMAS.

d. Reassessments made during the provision of services.

e. Records of contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the recipient.

f. All training provided to the personal assistants on behalf of the recipient or family/caregiver.

g. All recipient progress reports.

h. All management training provided to the recipient or family/caregivers, including the recipient's or family/caregiver's responsibility for the accuracy of the timesheets.

i. All documents signed by the recipient or the recipient's family/caregiver that acknowledge the responsibilities of the services.

6. The CD service facilitation provider is required to submit to DMAS biannually, for every recipient, a recipient progress report, an updated UAI, and any monthly visit/progress reports. This information is used to assess the recipient's ongoing need for Medicaid-funded long-term care and appropriateness and adequacy of services rendered.

7. The CD services facilitator must submit prior to beginning CD services a criminal record check of the personal assistant on behalf of the recipient and report findings of the criminal record check to the recipient or family/caregiver and the program's fiscal agent. DMAS will reimburse for up to six criminal record checks per recipient within a six-month period. Personal assistants will not be reimbursed for services provided to the recipient on or after the date the criminal record check confirms a personal assistant has been found to have been convicted of a crime as described in § 32.1-162.9:1 of the Code of Virginia or if the personal assistant has a confirmed record on the DSS Child Protective Services Registry. If the recipient is a minor, the personal assistant must also be screened through DSS child protective services registry.

8. The CD services facilitator shall verify bi-weekly timesheets signed by the recipient or the family/caregiver and the personal assistant to ensure that the number of plan of care approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must contact the recipient to resolve the discrepancies and must notify the fiscal agent. If a recipient is consistently being identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation. The CD services facilitator cannot verify timesheets for personal assistants whose criminal record checks have confirmed that they have been convicted of a crime described in § 32.1-162.9:1 of the *Code of Virginia* or in the case of a minor recipient have a confirmed case with the DSS Child Protective Services Registry and must notify the fiscal agent.

~~12VAC30-120-170~~. 12 VAC 30-120-160. Case management services.

The following are specific requirements governing the provision of case management services. Case management is one of ~~five~~ seven services covered under the home and community based care program for individuals with AIDS/ARC.

A. General. Case management services are offered to enable continuous assessment, coordination and monitoring of the needs of the persons diagnosed with AIDS or ARC throughout the term of the individual's receipt of waiver services. Every AIDS/ARC individual authorized for home and community-based services shall be offered case management services as an adjunct to other offered services. A Medicaid-eligible individual may not be authorized for home and community-based services unless that individual is both diagnosed with AIDS or ARC and is experiencing symptoms which require delivery of a home and community-based service other than case management. An individual authorized for home and community-based services for conditions of AIDS/ARC may continue to receive case management services during periods when other home and community-based services are not being utilized as long as receipt of case management services can be shown to continue to prevent the individual's institutionalization.

B. Special provider participation conditions. To be a participating case management provider the following conditions shall be met:

1. The provider shall employ case management staff responsible for the reevaluation of need, monitoring of service delivery, revisions to the Plan of Care and coordination of services. This staff shall possess, at a minimum:

a. A baccalaureate degree in human services (i.e., social work, psychology, sociology, counseling, or a related field) or nursing;

b. Knowledge of the infectious disease process (specifically HIV) and the needs of the terminally-ill population, knowledge of the community service network and eligibility requirements and application procedures for applicable assistance programs;

c. Ability to access other health and social work professionals in the community to serve as members of a multidisciplinary team for reevaluation and coordination of services activities, ability to organize and monitor an integrated service plan for individuals with multiple problems and limited resources, ability to access (or have expertise in) medical and clinical expertise related to HIV infection and ability to demonstrate liaisons with clinical facilities providing diagnostic evaluation and/or treatment for persons with HIV; and

d. Skills in communication, service plan development, client advocacy and monitoring of a continuum of managed care.

Documentation of all staffs' credentials shall be maintained in the provider agency's personnel file for review by DMAS staff. Providers of case management may utilize the services of volunteers or employees who do not meet this criteria to perform the day-to-day interactions with recipients commonly included in the case management process. There shall be, however, a case manager responsible for supervision of these volunteers or employees to include at a minimum weekly case consultations, decision-making related to the individual's Plan of Care and appropriateness for waiver services and training of the volunteers or employees interacting with the waiver recipient. The use of volunteers or other employees to perform the day-to-day interactions does not relieve the case manager from responsibility for direct contact (as defined below) with the recipient and overall responsibility for care management.

2. Designate a qualified staff person as case manager who shall:

a. Contact the waiver recipient, at a minimum, once every 30 days. If the waiver recipient has a volunteer(s) or other staff assigned for regular face-to face contact, this contact by the case manager may be a telephone contact. Otherwise, the contact by the case manager shall be a face-to-face interaction.

b. Contact the providers of direct waiver service(s), at a minimum, once every 30 days. Collateral contacts with other supports shall be made periodically, as determined by the needs of the recipient and extent of the support system.

c. Maintain a file for each recipient which includes:

(1) An ongoing progress report which documents all communications between the case manager and recipient, providers, and other contacts. If the case manager is supervising a volunteer or employee who is assigned to provide day-to-day case management interactions with the recipient, the volunteer or employee must submit to the case manager a monthly summary of all interactions between the volunteer or employee and the recipient,

(2) The recipient's assessment documentation and documentation of reassessments of level of care and need for services conducted quarterly by the case manager and the individual's case management team,

(3) The initial Plan of Care and all subsequent revisions,

(4) Communication from DMAS, physician, service providers, and any other parties.

d. Reviews of the Plan of Care every three months, or more frequently if necessary, and continue any revisions indicated by the changed needs or support of the recipient. These reviews shall be documented in the recipient's file. The documentation shall note all members of the case management team who provided input to the Plan of Care.

3. Maintain a ratio of case manager staff to recipient caseload which allows optimum monitoring and reevaluation ability. The caseload ability of the case manager may vary according to other duties, availability of resources, stage of recipients in caseload, and utilization of volunteers. A ratio of one case manager to a caseload size of 25 waiver recipients is deemed desirable, but can be exceeded as long as quality of case management services are not affected.

C. Nutritional supplement authorization. Nutritional supplements which do not contain a legend drug may be purchased for the recipient of waiver services for conditions of AIDS/ARC when the nutritional supplements are certified by the physician as the primary source of nutrition and necessary for the successful implementation of the individual's health care plan and the individual is not able to purchase these food supplements through other available means. The amount of nutritional supplements shall be limited by medical necessity and cost effectiveness. Case management providers shall authorize the purchase of physician-ordered nutritional supplements through the Plan of Care approved by DMAS or the designated preauthorization contractor. The case management provider shall complete an invoice authorizing the purchase which the

recipient can use to purchase the nonlegend drug nutritional supplements from an approved Medicaid provider.

~~12VAC30-120-180~~. 12 VAC 30-120-165. Personal care services.

The following requirements govern the provision of personal care services:

A. General. Personal care services are offered to ~~individuals in their homes~~ an individual as long-term maintenance or support services which are necessary in order to enable the individual to remain at or return home rather than enter a hospital or nursing facility. Personal care services provide eligible individuals with personal care aides who perform basic health-related services, such as helping with activities of daily living, assisting with ambulation, exercises, assisting with normally self-administered medications, reporting changes in recipient's conditions and needs, and/or providing household services essential to health in the home. Generally, personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes. Recipients may continue to work or attend post-secondary school, or both, while they receive services under this waiver. The personal care assistant 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 assistant 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.

B. DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) (42 USC §§ 12131 through 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 assistant to be with the recipient for any hours extending beyond lunch. For a recipient whose speech is such that he 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 assistant's services may be necessary for the length of time the recipient is at work or school or both. DMAS will reimburse for the assistant's services except for assistance services that are required to be provided by the employer or school under the ADA or the Rehabilitation Act but only to the extent such time and services are consistent with the recipient's plan of care.

C. The provider agency must develop an individualized plan of care that addresses the recipient's needs at home and work and in the community. DMAS will not pay for the assistant 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.~~ D. Special provider participation conditions. The personal care provider shall:

1. Demonstrate a prior successful delivery of health care services.

2. Operate from a business office.

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

a. The 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 a acute care hospital, public health clinic, home health agency, ~~or~~ nursing home, or as a Licensed Practical Nurse (LPN)).

b. The RN supervisor shall make an initial assessment home visit prior to the start of care for all new recipients admitted to personal care.

c. The RN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. A minimum frequency of these visits is every 30 days. The 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) The initial home assessment visit by the RN shall be conducted to create the plan of care and assess the recipients' needs. The RN supervisor 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 RN supervisor. Recipients who are determined to have a cognitive impairment will continue to have supervisory visits every 30 days.

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

(4) The provider agency has the responsibility of determining if 30-day RN supervisory visits are appropriate for the recipient. The provider agency may offer the extended RN supervisor 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.

(5) If a recipient's personal care assistant 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, 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. During visits to the recipient's home, the 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 RN summary shall note:

(1) Whether personal care services continue to be appropriate.

(2) Whether the plan is adequate to meet the need or changes are indicated in the plan.

(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 medical condition or functioning status.

(6) Other services received and their amount.

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

e. The 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 aide by telephone at all times that the aide is providing services to personal care recipients.

f. The RN supervisor shall evaluate the aide's performance and the recipient's individual needs to identify any gaps in the aide's abilities to function competently and shall provide training as indicated.

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:

a. Shall be able to read and write.

b. Shall complete 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. Shall be physically able to do the work.

d. Shall 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.

e. Shall not be ~~a member of the recipient's family (e.g., family is defined as parents, spouses, children, siblings, grandparents, and grandchildren).~~ parents of minor children or spouses.

~~C.~~ E. 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), 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. The two agencies involved shall negotiate the financial arrangements of paying 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.~~ F. Required documentation in recipients' records. The provider agency shall maintain all records of each personal care recipient. At a minimum these records shall contain:

1. The most recently updated Long Term Care Assessment Instrument, the Prescreening Authorization, the Screening Team Plan of Care, all provider agency plans of care, and all DMAS-122s.

2. All DMAS Utilization Review forms and plans of care.

3. Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated.

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

5. All correspondence to the recipient and to DMAS.

6. Reassessments made during the provision of services.

7. Contacts made with family, physicians, DMAS, formal, informal service providers and all professionals concerning the recipient.

8. 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.

b. The aide's arrival and departure times.

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

d. The aide's and recipient's weekly signature to verify that personal care services during that week have been rendered.

e. 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.

~~12VAC30-120-190~~. 12 VAC 30-120-175. 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 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 30 24-hour days over a 12-month period. Reimbursement shall be made on an hourly basis.~~ The authorization of respite care is limited to 720 hours per calendar year per recipient. A recipient who transfers to a different provider or is discharged and readmitted into the HIV/AIDS waiver program 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.

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

1. Demonstrate prior successful health care delivery.

2. Operate from a business office.

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

a. The 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, ~~or~~ nursing home, or as an LPN.

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

c. The RN supervisor shall make an initial assessment visit prior to the start of care for any recipient admitted to respite care.

d. The RN supervisor 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 RN supervisor shall not be required to conduct a supervisory visit every 30 days. Instead, the RN supervisor shall conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.~~ When respite care services are not received on a routine basis, but are episodic in nature, an RN shall not be required to conduct a supervisory visit every 30 days. Instead, an RN shall conduct the initial home assessment visit with the respite care aide on or before the start of care and make a second home visit 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 may serve as the RN visit for respite care. However, the RN supervisor shall document supervision of respite care separately. For this purpose, the same recipient record can be used with a separate section for respite care documentation~~. When respite care services are routine in nature and offered in conjunction with personal care, the supervisory visit conducted for personal care services may serve as the registered nurse supervisory visit for respite care. However, the registered nurse 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. During visits to the recipient's home, the 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 the recipient's or family's satisfaction with the type and amount of service discussed. The 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 in it.

(3) The recipient's satisfaction with the service.

(4) Any hospitalization or change in medical condition or functioning status.

(5) Other services received and their amount.

(6) The presence or absence of the aide in the home during the visit.

f. In all cases, the RN shall be available to the respite care aide to discuss the recipients being served by the aide.

g. 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.

4. 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. Each aide:

a. Shall be able to read and write.

b. Shall have completed 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. Shall be evaluated in job performance by the RN supervisor.

d. Shall have the physical ability to do the work.

e. Shall have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse or neglect of incompetent and/or incapacitated individuals.

f. Shall not be ~~a member of a recipient's family (e.g., family is defined as parents, spouses, siblings, grandparents, and grandchildren).~~ parents of minor children or spouses.

5. The respite care agency may employ a licensed practical nurse (LPN) to deliver respite care services which shall be reimbursed by DMAS under the following circumstances:

a. The individual receiving care 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 home (i.e., recipients on a ventilator, recipients requiring nasogastric or gastrostomy feedings).

b. 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. The recipient is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver.

d. The agency can document 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 and case manager.

3. If a substitute aide is secured from another respite care provider agency or other home care agency, 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 recipients.

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. Required documentation for 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. These records shall be reviewed periodically by the DMAS staff. At a minimum these records shall contain:

1. Long Term Care Assessment Instrument, the Prescreening Authorization, all Respite Care Assessment and Plans of Care, and all DMAS-122s.

2. All DMAS Utilization Review Forms and Plans of Care.

3. Initial assessment by the RN supervisor completed prior to or on the date services are initiated.

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

5. All correspondence to the recipient and to DMAS.

6. Reassessments made during the provision of services.

7. Significant contacts made with family, physicians, DMAS, and all professionals concerning the recipient.

8. Respite care aide record of services rendered and recipient's responses. The aide record shall contain:

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

b. The arrival and departure time of the aide for respite care services only.

c. Comments or observations recorded weekly about the recipient. Aide 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.

d. The signature by the aide, or LPN, and the recipient once each week to verify that respite care services have been rendered.

e. 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.

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.

12VAC30-120-200. Skilled nursing services.

These requirements govern the provision of skilled nursing services.

A. General. Skilled nursing services may be offered to individuals with AIDS/ARC when such services are deemed necessary by the physician to avoid institutionalization by assessment and monitoring of the medical condition, providing interventions, and communicating with the physician regarding changes in the patient's status. The hours of private duty nursing shall be limited by medical necessity and cost effectiveness.

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

1. Be a home health agency certified by the Virginia Department of Health for Medicaid participation, with which DMAS has a contract for private duty nursing.

2. Demonstrate a prior successful health care delivery.

3. Operate from a business office.

4. Employ or subcontract with and directly supervise a registered nurse (RN) or a licensed practical nurse with a current and valid license issued by the Virginia State Board of Nursing.

The 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, or nursing home.