12VAC30-120-10. ~~Definitions.~~ REPEALED.

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

~~"Activities of daily living" or "ADL" means personal care tasks (e.g., bathing, dressing, toileting, transferring, and eating/feeding). An individual's degree of independence in performing these activities is part of determining the appropriate level of care and service needs.~~

~~"Adult day health care center" means a participating provider that 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.~~

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

~~"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.~~

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

~~"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 giveaways, 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.~~

~~"DMAS" means the Department of Medical Assistance Services.~~

~~"DSS" means the Department of Social Services.~~

~~"Episodic respite care" means services specifically designed to provide relief to the primary unpaid caregiver for a nonroutine, short-term period of time for a specified reason (e.g., 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, respite care, and personal emergency response systems (PERS)) authorized under a Social Security Act §1915(c) Elderly and Disabled waiver designed to offer individuals an alternative to nursing facility 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 services in order 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, DMAS or the designated preauthorized contractor shall give prior authorization for any Medicaid-reimbursed home and community-based care.~~

~~"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.~~

~~"Medication monitoring" means an electronic device that enables certain recipients at high risk of institutionalization to be reminded to take their medications at the correct dosages and times.~~

~~"Nursing home preadmission screening" 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 home or community-based care for those individuals who meet nursing facility level of care.~~

~~"Nursing Home Preadmission Screening Committee/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.~~

~~"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 care agency" means a participating provider that 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 are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. It may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.~~

~~"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.~~

~~"Plan of Care" means the written 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.~~

~~"Reconsideration" means the supervisory review of information submitted to DMAS in the event that a decision to deny the reimbursement of services is made at an analyst's level.~~

~~"Respite care" means services specifically designed to provide a temporary, 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 that 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 services specifically designed to provide relief to the primary unpaid caregiver on a periodic basis over an extended period of time to allow the caregiver a routine break from continuous care (e.g., respite care offered one day a week for six hours).~~

~~"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.~~

~~"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.~~

~~"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that assesses an individual's social, physical health, mental health, and functional abilities.~~

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

~~A. Coverage statement.~~

~~1. Coverage shall be provided under the administration of 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) of the Social Security Act related to comparability of services.~~

~~B. Patient eligibility requirements.~~

~~1. Virginia has elected to cover low income families with children as described in §1931 of the Social Security Act; aged, blind, or disabled individuals who are eligible under 42 CFR 435.121; optional categorically needy individuals who are aged and disabled who have incomes at 80% of the federal poverty level; the special home and community-based waiver 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.~~

~~2. Reserved.~~

~~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. "Imminent risk" is defined as within one month. 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 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.~~

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

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

~~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 and initiate referrals for service.~~

~~6. Home and community-based care services shall not be offered or provided to any individual who resides in a nursing facility, an intermediate care facility for the mentally retarded, a hospital, or an assisted living facility licensed or certified by DSS. Additionally, home and community-based care services shall not be provided to any individual who resides outside of the physical boundaries of the Commonwealth, with the exception of brief periods of time as approved by DMAS or the designated~~

~~preauthorization contractor. Brief periods of time may include, but are not necessarily restricted to, vacation or illness.~~

~~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). Preadmission screenings are valid for the following periods of time: (i) month 0-6 - no updates needed; (ii) month 6-12 - update needed (do not submit for reimbursement); and (iii) over 12 months - new screening must be completed (submit for reimbursement).~~

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

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

~~A. All providers must meet the general requirements and conditions for provider participation. In addition, there are specific requirements for each of the service providers (personal care, respite care, adult day health care, and PERS) that are set forth in 12VAC30-120-40 through 12VAC30-120-60.~~

~~B. 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 (i) Title VI of the Civil Rights Act of 1964 (42 USC §2000 et seq.), which prohibits discrimination on the grounds of race, color, religion, or national origin; (ii) §504 of the Rehabilitation Act of~~

~~1973 (29 USC §70 et seq.), which prohibits discrimination on the basis of disability; and (iii) Title II of the Americans with Disabilities Act of 1990 (42 USC §126 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.~~

~~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 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 federal or 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 only for authorized DMAS purposes 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.~~

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

~~D. Provider participation standards. For DMAS to approve contracts with home and community-based care providers, providers must meet staffing, financial solvency, disclosure of ownership and assurance of comparability of services requirements as specified in DMAS' Elderly and Disabled Waiver Services Manual published July 1, 2002.~~

~~E. 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.~~

~~F. 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 choice from among those agencies that can appropriately meet the individual's needs.~~

~~G. Termination of provider participation. DMAS may administratively terminate a provider from participation upon 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. Payment by DMAS is prohibited for services provided to recipients subsequent to the date specified in the termination notice.~~

~~H. 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, 30 days from the date of the notice to request the informal conference, and 30 days to request the formal evidentiary hearing.~~

~~3. An appeal of adverse actions shall be heard in accordance with 12VAC30-10-1000 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.~~

~~I. Participating provider agency's responsibility for the Patient 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) that cause home and community-based care services to cease or be interrupted for more than 30 days.~~

~~J. 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 if 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, the recipient has the right to reconsideration by DMAS or the designated preauthorization contractor.~~

~~b. The participating provider is responsible for devising the new 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, 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.~~

~~2. Increases in the amount of authorized care. If a change in the recipient's condition 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, 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 DMAS, or the designated preauthorization contractor.~~

~~3. Nonemergency termination of home and community-based care services by the participating provider. The participating ADHC, personal care and respite care 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 the termination of services shall be at least five days from the date of the termination notification letter. The PERS provider shall give the recipient or family, or both, 14 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 the termination of services shall be at least 14 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, 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.~~

~~If the recipient disagrees with the service termination decision, DMAS or the designated preauthorization contractor shall conduct a review of the recipient's service needs as part of the reconsideration process.~~

~~K. Suspected abuse or neglect. Pursuant to §63.2-1606 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, or exploitation shall report this to the local DSS.~~

~~L. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring and compliance with provider participation standards and DMAS policies. 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.~~

~~M. 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 list that specifies the information that is being requested.~~

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

~~The following are specific requirements governing the provision of adult day health care (ADHC):~~

~~A. General. Adult day health care services may be offered to individuals in a congregate daytime setting as an alternative to 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, respite care, or PERS.~~

~~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 DMAS for verification purposes prior to the applicant's enrollment as a Medicaid provider and shall be available for DMAS review;~~

~~2. Adhere to DSS adult day care center standards. 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 provide a separate room or an area equipped with one bed, cot, or recliner for every 12 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 center shall maintain a minimum staff-to-participant ratio of one staff member to every six participants. This includes Medicaid and other participants;~~

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

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

~~d. Volunteers 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;~~

~~e. Any center that is collocated with another facility shall count only its own separate identifiable staff in the center's 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, and shall be responsible for responding to communication from DMAS and the designated preauthorization contractor. The director shall be responsible for assuring the development of the 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 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 center shall employ or subcontract with a registered nurse who shall be responsible for administering and monitoring the health needs of the participants. The nurse shall be responsible for the planning, organization, and management of the plan of care involving multiple services where specialized health care knowledge is needed. The nurse shall be present a minimum of eight hours each month at the center. 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 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, to the center's participants and staff during all times that the center is in operation.~~

~~h. The director shall assign 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 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 qualifications 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 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 available for review by DMAS staff who are authorized by the agency to review these files. 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' Elderly and Disabled Waiver Services Manual published July 1, 2002.~~

~~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, 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 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.~~

~~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 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.~~

~~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 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 center's fee for service but must be rendered as a separate service by a rehabilitative provider.~~

~~4. Nutrition responsibilities. The 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. Adult day health care coordination. The designated adult day health care coordinator shall coordinate the delivery of the activities as prescribed in the participants' plan of care and keep it updated, record 30-day progress notes, and review the participants' daily records each week.~~

~~6. Recreation and social activities responsibilities. The 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 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 Uniform Assessment Instrument, the Medicaid Long-Term Care Service Authorization form (DMAS-96), and the Screening Team Service Plan for Medicaid-Funded Long-term Care;~~

~~2. Interdisciplinary plans of care developed by the center's director, registered nurse, or therapist; 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 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 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 records of services provided. The daily record shall contain the specific services delivered by center staff. The record shall also contain the arrival and departure times of the participant and be signed weekly by the director, activities director, registered nurse, or therapist employed by the center. The daily 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 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, DMAS, and the designated preauthorization contractor.~~

12VAC30-120-50. ~~Personal care services.~~ REPEALED.

~~The following requirements govern the provision of personal care services.~~

~~A. General. Personal care services may be offered to individuals as an alternative to 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, respite care, or PERS.~~

~~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 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 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 that addresses the recipient's needs at home and 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. Operate from a business office;~~

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

~~a. The registered nurse 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, 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.~~

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

~~d. The registered nurse 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 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.~~

~~(3) 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.~~

~~(4) 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.~~

~~(5) 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 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.~~

~~e. During visits to the recipient's home, a registered nurse 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 summary shall note:~~

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

~~(2) Whether the plan is adequate to meet the recipient's needs or if changes 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 the amount; and~~

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

~~f. 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.~~

~~g. The registered nurse supervisor shall evaluate the aides' performance and the recipient's needs to identify any insufficiencies in the aides' abilities to function competently and shall provide training as indicated. This shall be documented in the recipient's record.~~

~~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. Employ and directly supervise personal care aides who 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 qualifications 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 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: (i) the parents of minor children who are receiving waiver services or (ii) spouses of individuals who are receiving waiver services; and~~

~~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. Required documentation for recipients' records. The provider agency shall maintain all records of each personal care recipient. These records shall be separate from those of nonhome 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 the record shall contain:~~

~~1. The most recently updated Long-Term Care Uniform Assessment Instrument, the Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), all provider agency plans of care, and all Patient Information forms (DMAS-122);~~

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

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

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

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

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

~~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, 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 as documented in the record. An employee 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~~

~~8. All recipient progress reports.~~

12VAC30-120-55. ~~**Personal emergency response system (PERS) services.**~~ **REPEALED.**

~~A. Service description. PERS is a service that 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. A recipient may not receive PERS if he has a cognitive impairment as defined in 12VAC30-120-10.~~

~~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, adjustments, 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 cannot 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 (copyright 2002) and Number 1637 for Home Health Care Signaling Equipment (copyright 2002). 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 recordkeeping 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 that 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 Patient Information form (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.~~ REPEALED.

~~These requirements govern the provision of respite care services.~~

~~A. General. Respite care services may be offered to individuals as an alternative to 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. A recipient who transfers to a different provider or is discharged and readmitted into the Elderly and Disabled Individuals 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. Operate from a business office.~~

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

~~a. The registered nurse 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, 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.~~

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

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

~~e. 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, a registered nurse shall not be required to conduct a supervisory visit every 30 days. Instead, a registered nurse 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 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.~~

~~f. During visits to the recipient's home, the registered nurse 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 along with the recipient's or family's satisfaction with the type and amount of service discussed. The registered nurse 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 the amount of the services received; and~~

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

~~g. 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.~~

~~h. 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.~~

~~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 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 supervisor;~~

~~d. 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 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 checks shall be available for review by DMAS staff who are authorized by the agency to review these files.~~

~~f. Not be: (i) the parents of minor children who are receiving waiver services or (ii) the spouses of individuals 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. The Respite Care Agency may employ a licensed practical nurse to 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;

b. The 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 (e.g., recipients on a ventilator, recipients requiring nasogastric, or gastrostomy feedings, etc.);

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;

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; and

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

C. 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 nonhome 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 shall contain:

1. The most recently updated Long-Term Care Uniform Assessment Instrument, the Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), all respite care assessments and plans of care, and all Patient Information forms (DMAS-122);

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

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;

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

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

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

~~7. All respite care aide records. 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 times of the aide or LPN for respite care services;~~

~~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 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. An employee of the provider shall not sign for the recipient unless he is a family member or legal guardian of the recipient.~~

~~8. All recipient progress reports.~~

~~12VAC30-120-490. Definitions.~~ REPEALED.

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

~~"Committee for recipient" means a person who has been legally invested with the authority, and charged with the duty of managing the estate or making decisions to promote the well-being of a person who has been determined by the circuit court to be totally incapable of taking care of his person or handling and managing his estate because of mental illness or mental retardation. A committee shall be appointed only if the court finds that the person's inability to care for himself or handle and manage his affairs is total.~~

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

~~"DMAS" means the Department of Medical Assistance Services.~~

~~"DRS" means the Department of Rehabilitative Services. DRS currently operates the Personal Assistance Services Program, which is a state-funded program that provides a limited amount of personal care services to Virginians.~~

~~"DSS" means the Department of Social Services.~~

~~"Family or caregiver" means a spouse, parent, adult child, or guardian. A family or caregiver may direct the care on behalf of the recipient if a recipient is incapable of directing his own care.~~

~~"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 attendant services (PAS).~~

~~"Guardian" means a person who has been legally invested with the authority and charged with the duty of taking care of the recipient and managing his property and protecting the rights of the recipient who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the recipient in need of a guardian has been determined to be incapacitated.~~

~~"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS (personal care, adult day health care, respite care, and~~

~~assisted living,) authorized under a Social Security Act §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 in order to avoid nursing facility placement. The Nursing Home Preadmission Screening Team or DMAS shall give prior authorization for any Medicaid-funded home and community-based care.~~

~~"Instrumental activities of daily living" or "IADL" means social tasks, i.e., meal preparation, shopping, housekeeping, laundry, money management. A person'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/paying for groceries and carrying them home. Housekeeping is dusting, washing dishes, making beds, vacuuming, cleaning floors, and cleaning bathroom/kitchen. Laundry is washing/drying clothes. Money management is paying bills, writing checks, handling cash transactions, and making change.~~

~~"Nursing Home Preadmission Screening (NHPAS)" means the process to (i) evaluate the medical, nursing, and social needs 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 and require that level of care.~~

~~"Nursing Home Preadmission Screening Team" means the entity contracted with DMAS which 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. For individuals in an acute care facility who require screening, the entity is a team of nursing and social work staff. A physician shall be a member of both the local committee or 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 attendant" means, for purposes of this part and exemption from Worker's Compensation, a domestic servant. Consumers shall be restricted from employing more than two personal attendants simultaneously at any given time.~~

~~"Personal attendant services" or "PAS" means long-term maintenance or support services necessary to enable the mentally alert and competent individual to remain at or return home rather than enter a nursing care facility. Personal attendant services include hands-on care specific to the needs of a medically stable, physically disabled individual.~~

~~Personal attendant services include assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and external catheter care as further defined in the Consumer-Directed PAS Manual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical function. When specified, supportive services may include assistance with IADLs which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Personal attendant services shall not include either practical or professional nursing services as defined in Chapters 30 and 34 of Title 54.1 of the Code of Virginia, as appropriate.~~

~~"Plan of care" or "POC" means the written plan of services certified by the screening team physician and approved by DMAS as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.~~

~~"Providers" means those individuals, agencies or facilities registered, licensed, or certified, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.~~

~~"Service coordination 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 coordination provider shall meet the knowledge, skills, and abilities as further defined in this part.~~

~~"State Plan for Medical Assistance" or "the Plan" means the document describing 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.~~

~~12VAC30-120-500. General coverage and requirements for consumer-directed PAS as a home and community-based care waiver service~~. REPEALED.

~~A. Coverage statement. Coverage of consumer-directed PAS shall be provided under the administration of the DMAS to disabled and elderly individuals who must be mentally alert and have no cognitive impairments who would otherwise require the level of care provided in a nursing facility. Individuals must be able to manage their own affairs without help from another individual. Individuals eligible for consumer-directed PAS must have the capability to hire and train their own personal attendants and supervise the~~

~~attendant's performance. If a recipient is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient.~~

~~B. Individuals receiving services under this waiver must meet the following requirements:~~

~~1. Individuals receiving services under this waiver must be eligible under one of the following eligibility groups: aged, blind or disabled recipients eligible under 42 CFR 435.121, and the special home and community-based waiver group at 42 CFR 435.217 which includes individuals who would be eligible under the State Plan if they were institutionalized.~~

~~2. Under this waivered service, the coverage groups authorized under §1902(a)(10)(C)(i)(III) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules.~~

~~3. Virginia shall reduce its payment for home and community-based care services provided for an individual 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. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after deducting the amounts as specified in 42 CFR 435.726, listed below:~~

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

~~(1) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) disregarded for maintenance exceed 300% of SSI.~~

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

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

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

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

~~(1) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) disregarded for maintenance exceed 300% of SSI.~~

~~(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 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 in the near future. "Imminent risk" is defined as within one month. 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 home and community-based care services shall be determined by the NHPAS 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 NHPAS Team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.~~

~~3. An essential part of the NHPAS Team's assessment process is determining the level of care required by applying existing criteria for nursing facility care according to established nursing home preadmission screening processes.~~

~~4. The team shall explore alternative settings or services to provide the care needed by the individual. If nursing facility 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 nursing facility placement, the screening team shall develop an appropriate plan of care and initiate referrals for service.~~

~~5. The annual cost of care for home and community-based care services for a recipient shall not exceed the average annual cost of nursing facility care. For purposes of this subdivision, the annual cost of care for home and community-based care services for a recipient shall include all costs of all Medicaid covered services which would actually be received by the recipient. The average annual cost of nursing facility care shall be determined by DMAS and shall be updated annually.~~

~~6. Home and community-based care services shall not be provided to any individual who resides in a board-and-care facility or adult care residences (ACRs) nor who is an inpatient in general acute care hospitals, skilled or intermediate nursing facilities, or intermediate care facilities for the mentally retarded. Additionally, home and community-based care services shall not be provided to any individual who resides outside of the physical boundaries of the Commonwealth, with the exception of brief periods of time as approved by DMAS. Brief periods of time may include, but are not necessarily restricted to, vacation or illness.~~

~~7. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by the NHPAS Team.~~

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

~~12VAC30-120-510. General conditions and requirements for home and community-based care participating service coordination providers.~~ REPEALED.

~~A. Service coordination providers approved for participation shall, at a minimum, perform the following activities:~~

~~1. Accept referrals for services only when staff is available to initiate and perform such services on an ongoing basis.~~

~~2. Provide services and supplies to recipients in full compliance with (i) Title VI of the Civil Rights Act of 1964 (42 USC §2000 et seq.) which prohibits discrimination on the grounds of race, color, religion, or national origin; (ii) §504 of the Rehabilitation Act of 1973 (29 USC §70 et seq.) which prohibits discrimination on the basis of a disability and; (iii) Title II of the Americans with Disabilities Act of 1990 (42 USC §126 et seq.) which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications.~~

~~3. 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. Also assure the recipient's freedom to reject medical care and treatment.~~

~~4. Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.~~

~~5. 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.~~

~~6. Submit charges to 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. The provider will accept as payment in full the amount established by DMAS payment methodology from the first day of eligibility.~~

~~7. Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS. The provider will use program-designated billing forms for submission of charges.~~

~~8. Furnish to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit information on request and in the form~~

~~requested. The Commonwealth's right of access to provider agencies and records shall survive any termination of this agreement.~~

~~9. Disclose 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.~~

~~10. Hold confidential and use for authorized DMAS purposes only all medical and identifying information regarding recipients served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.~~

~~11. When ownership of the provider agency changes, notify DMAS within 15 calendar days prior to the date of the change.~~

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

~~C. For DMAS to approve contracts with home and community-based care providers the following provider participation standards shall be met:~~

~~1. Financial solvency.~~

~~2. Disclosure of ownership.~~

~~3. Staffing requirements.~~

~~D. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider contracts.~~

~~E. 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 must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies which have been cited.~~

~~F. 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.~~

~~G. A participating service coordinator provider may voluntarily terminate his participation in Medicaid by providing 30 days written notification. DMAS shall be permitted to administratively terminate a service coordinator provider from participation upon 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. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice.~~

~~H. A provider shall have the right to appeal adverse action taken against it by DMAS. Adverse action includes, but shall not be limited to, termination of the provider agreement by DMAS, and retraction of payments from the provider by DMAS for noncompliance with applicable law, regulation, policy or procedure. All disputes regarding provider reimbursement or termination of the agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be conducted pursuant to the Virginia 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 and duly promulgated regulations. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.~~

~~I. Section 32.1-325 C of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. Reinstatement will be contingent upon provisions of state law. Additionally, termination of a provider contract will occur as may be required for federal financial participation.~~

~~J. It is the responsibility of the provider agency to notify DMAS and DSS, in writing on form DMAS-122, 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.~~

~~K. It shall be the responsibility of the provider agency to notify DMAS, in writing, within five days when any of the following changes in the authorized hours or termination of provider agency services occur:~~

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

~~a. The provider 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 POC is appropriate.~~

~~b. The participating provider is responsible for devising the new POC 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, document the conversation in the recipient's record, and shall notify the recipient of the change by letter.~~

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

~~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 participating provider shall assess the need for increase and, if appropriate, develop a plan of care with the recipient for services to meet the changed needs. The provider may implement the increase in hours without approval from DMAS as long as the amount of service does not exceed the amount established by DMAS 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 pre-approved by DMAS. However, in no case shall the number of hours authorized exceed those established by the agency's individual cost effectiveness formula.~~

~~3. Nonemergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient 10 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 10 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, DMAS must be notified prior to termination. The 10-day written notification period shall not be required. If appropriate, the local DSS Adult Protective Services supervisor must be notified immediately.~~

~~L. 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, or exploitation shall report this immediately but no later than 48 hours from first knowledge to the local DSS adult protective services worker and to DMAS.~~

~~M. 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 recertify each provider for contract renewal with DMAS to provide home and community-based services. A provider's noncompliance with DMAS regulations, policies and procedures may result in retraction of funds or termination of the provider agreement.~~

~~12VAC30-120-520. Personal attendant services (PAS).~~ REPEALED.

~~A. Consumer-directed PAS may be offered to individuals in their homes as an alternative to more costly institutional nursing facility care. When the individual referred for consumer-directed PAS is already receiving another home and community-based care service, the DMAS utilization review staff shall assess the individual to determine the eligibility for consumer-directed PAS and authorize it if necessary to avoid more costly nursing facility care. In no event shall the services exceed cost effectiveness for this individual.~~

~~B. In addition to the general requirements above, to be enrolled as a Medicaid service coordination provider and maintain provider status, the following requirements shall be met:~~

~~1. The service coordination provider shall operate from a business office.~~

~~2. The service coordination provider must have sufficient qualified staff who will function as service coordinators to perform the needed POC development and monitoring, reassessments, service coordination, and support activities as required by the Consumer-Directed Personal Attendant Services Program.~~

~~3. It is preferred that the individual employed by the service coordination provider 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 individual have two years of satisfactory experience in the human services field working with persons with severe physical disabilities or the~~

~~elderly. The individual shall possess a combination of work experience and relevant education which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the application form, found in supporting documentation. or observed during the interview. Observations during the interview must be documented. The knowledge, skills, and abilities shall include, but not necessarily be limited to:~~

~~a. Knowledge of:~~

~~(1) Types of functional limitations and health problems that are common to different disability types and the aging process, as well as strategies to reduce limitations and health problems;~~

~~(2) Physical assistance typically required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;~~

~~(3) Equipment and environmental modifications commonly used and required by people with physical disabilities or elderly persons which reduces the need for human help and improves safety;~~

~~(4) Various long-term care program requirements, including nursing home and adult care residence placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance services;~~

~~(5) DMAS consumer directed personal attendant services program 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 attendant care services, including hiring, training, managing, approving time sheets, and firing an attendant;~~

~~(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) Observing, recording, and reporting behaviors;~~

~~(3) Identifying, developing, or providing services to persons with severe disabilities or elderly persons; 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 persons 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 persons from diverse cultural backgrounds.~~

~~4. If the service coordinator staff employed by the service coordination provider is not a registered nurse, the service coordination provider must have registered nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The RN consultant is to be available as needed to consult with recipients/service coordination providers on issues related to the health needs of the recipient.~~

~~5. Service coordination provider duties.~~

~~a. The service coordination provider must make an initial, comprehensive home visit to develop the POC with the recipient or family or caregiver and provide management training. Recipients or family or 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 POC. The service coordination provider will continue to monitor the POC 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 90 days per recipient. The initial comprehensive visit is done only once upon the recipient's entry into the program. If a waiver recipient changes service coordination provider agencies the new service coordination provider shall bill for a reassessment in lieu of a comprehensive visit.~~

~~b. 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 service coordination provider shall observe, evaluate and document the adequacy and appropriateness of personal attendant services with regard to the recipient's current functioning and cognitive status, medical and social needs. The service coordination provider shall discuss the recipient's satisfaction with the type and amount of service. The service coordination provider's summary shall include, but not necessarily be limited to:~~

~~(1) Whether personal attendant services continue to be appropriate and medically necessary to prevent institutionalization;~~

~~(2) Whether the POC is adequate to meet the needs of the recipient;~~

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

~~(4) Recipient's or family or caregiver's satisfaction with the service;~~

~~(5) Hospitalization or change in medical condition, functioning or cognitive status;~~

~~(6) Other services received and their amount; and~~

~~(7) The presence or absence of the attendant in the home during the service coordinator's visit.~~

~~5. The service coordination provider shall be available to the recipient by telephone.~~

~~6. The service coordination provider will submit a criminal record check pertaining to the personal attendant on behalf of the recipient and report findings of the criminal record check to the recipient or family or caregiver. Personal attendants will not be reimbursed for services provided to the recipient effective with the date the criminal record check confirms a personal attendant has been found to have been convicted of a crime as described in 12VAC30-90-180.~~

~~7. The service coordination provider shall verify biweekly timesheets signed by the recipient or family or caregiver and the personal attendant to ensure the number of approved hours on the POC are not exceeded. If discrepancies are identified, the service~~

~~coordination provider will contact the recipient or family or caregiver to resolve discrepancies and will notify the fiscal agent. If a recipient or family or caregiver is consistently being identified as having discrepancies in his timesheets, the service coordination provider will contact DMAS to resolve the situation. Service coordination providers shall not verify timesheets for personal attendants who have been convicted of crimes described in 12VAC30-90-180 and will notify the fiscal agent.~~

~~C. The service coordination provider shall maintain a personal attendant registry. The registry shall contain names of persons who have experience with providing personal attendant services or who are interested in providing personal attendant services. The registry shall be maintained as a supportive source for the recipient who may use the registry to obtain names of potential personal attendants.~~

~~D. The service coordination provider shall maintain all records of each consumer-directed PAS recipient. At a minimum these records shall contain:~~

~~1. All copies of the completed UAIs, the Long-Term Care Preadmission Screening Authorization (DMAS-96), all plans of care, and all DMAS-122's.~~

~~2. All DMAS utilization review forms.~~

~~3. Service coordination provider's notes contemporaneously recorded and dated during any contacts with the recipient and during visits to the recipient's home.~~

~~4. All correspondence to the recipient and to DMAS.~~

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

~~6. Records of contacts made with family, physicians, DMAS, formal, informal service providers and all professionals concerning the recipient.~~

~~7. All training provided to the personal attendant or attendants on behalf of the recipient.~~

~~8. All recipient progress reports, as specified in subsection E of this section.~~

~~9. All management training provided to the recipients or family or caregivers, including the recipient's or family or caregiver's responsibility for the accuracy of the timesheets.~~

~~E. The service coordination 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.~~

~~F. Recipients or family or caregivers will hire their own personal attendants and manage and supervise the attendants' performance.~~

~~1. Attendant qualifications include, but shall not be necessarily limited to the following requirements. The attendant must:~~

~~a. Be 18 years of age or older;~~

~~b. Have the required skills to perform attendant care services as specified in the recipient's POC;~~

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

~~d. Possess a valid social security number;~~

~~e. Submit to a criminal records check. The personal attendant will not be compensated for services provided to the recipient if the records check verifies the personal attendant has been convicted of crimes described in 12VAC30-90-180;~~

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

~~g. Understand and agree to comply with the DMAS Consumer-Directed PAS Program requirements; and~~

~~h. Be willing to register in a personal attendant registry, which will be maintained by the provider agency chosen by the recipient.~~

~~2. Restrictions. Attendants shall not be a parent or stepparent of a minor child or a recipient's spouse. In addition, anyone who has legal guardianship or is a committee for the recipient shall also be prohibited from being an attendant under this program.~~

~~G. The recipient's inability to obtain personal attendant services and substitution of attendants. The service coordination provider shall note on the Plan of Care what constitutes the recipient's backup plan in case the personal attendant does not report for work as expected or terminates employment without prior notice. Upon the recipient's request, the service coordination provider shall provide the recipient with a list of persons on the personal attendant registry who can provide temporary assistance until the attendant returns or the recipient is able to select and hire a new personal attendant. If a recipient is consistently unable to hire and retain the employment of an attendant to provide personal attendant services, the service coordination provider must:~~

~~1. Contact DMAS to transfer the recipient to a provider which provides Medicaid-funded agency-directed personal care services. The service coordination provider will make arrangements to have the recipient transferred, or~~

~~2. Contact the local health department and request a Nursing Home Preadmission Screening to determine if another long-term care option is appropriate.~~

~~12VAC30-120-530. Fiscal services.~~ **REPEALED.**

~~A. DMAS shall be permitted to contract for the services of a fiscal agent. The fiscal agent will be reimbursed by the DMAS to perform certain tasks as an agent for the recipient/employer who is receiving consumer-directed PAS. The fiscal agent will handle responsibilities for the recipient 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 these duties.~~

~~B. A fiscal agent may be a state agency or other organization, and will sign a contract with the DMAS that clearly defines the roles and tasks expected of the fiscal agent and the DMAS and enroll as a provider of consumer-directed PAS. Roles and tasks which will be defined for the fiscal agent in the contract will consist of but not necessarily be limited to the following:~~

~~1. The fiscal agent will file for and obtain employer agent status with the federal and state tax authorities;~~

~~2. Once the recipient has been authorized to receive consumer-directed PAS, the fiscal agent will register the recipient or family or caregiver as an employer, including providing assistance to the recipient or family or caregiver in completing forms required to obtain employer identification numbers from federal agencies, state agencies, and unemployment insurance agencies;~~

~~3. The fiscal agent will prepare and maintain original and file copies of all forms needed to comply with federal, state, and local tax payment, payment of unemployment compensation insurance premiums, and all other reporting requirements of employers;~~

~~4. Upon receipt of the required completed forms from the recipient, the fiscal agent will remit the required forms to the appropriate agency and maintain copies of the forms in the recipient's file. The fiscal agent will return copies of all forms to the recipient or family or caregiver for the recipient's or family or caregiver's permanent personnel records;~~

~~5. The fiscal agent will prepare all unemployment tax filings on behalf of the recipient as employer, and make all deposits of unemployment taxes withheld according to the appropriate schedule;~~

~~6. The fiscal agent will receive and verify the attendant biweekly timesheets do not exceed the maximum hours approved for the recipient and will process the timesheets.~~

~~7. The fiscal agent will prepare and process the payroll for the recipient's attendants, performing appropriate income tax, FICA and other withholdings according to federal and state regulations. Withholdings include, but are not limited to, all judgments, garnishments, tax levies or any related holds on the funds of the attendants as may be required by local, state, or federal law;~~

~~8. The fiscal agent will prepare payrolls for the recipient's personal attendant according to approved time sheets and after making appropriate deductions;~~

~~9. The fiscal agent will make payments on behalf of the recipient for FICA (employer and employee shares), unemployment compensation taxes, and other payments required and as appropriate;~~

~~10. The fiscal agent will distribute biweekly payroll checks to the recipient's attendants on behalf of the recipient;~~

~~11. The fiscal agent will maintain accurate payroll records by preparing and submitting to DMAS, at the time the fiscal agent bills DMAS for personal attendant services, an accurate accounting of all payments on personal attendants to whom payments for services were made, including a report of FICA payments for each covered attendant;~~

~~12. The fiscal agent will maintain such other records and information as DMAS may require, in the form and manner prescribed by DMAS;~~

~~13. The fiscal agent will generate W-2 forms for all personal attendants who meet statutory threshold amounts during the tax year;~~

~~14. The fiscal agent will establish a customer service mechanism in order to respond to calls from recipients and personal attendants regarding lost or late checks, or other questions regarding payments that are not related to the authorization amounts generated from DMAS;~~

~~15. The fiscal agent will keep abreast of all applicable state and federal laws and regulations relevant to the responsibilities it has undertaken with regard to these filings;~~

~~16. The fiscal agent will use program-designated billing forms or electronic billing to bill DMAS; and~~

~~17. The fiscal agent will be capable of requesting electronic transfer of funds from DMAS.~~

~~C. The fiscal agent and all subcontracting bookkeeping firms, as appropriate, will maintain the confidentiality of Medicaid information in accordance with the following:~~

~~1. The fiscal agent agrees to ensure that access to Medicaid information will be limited to the fiscal agent. The fiscal agent shall take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession. The fiscal agent shall establish internal policies to ensure compliance with federal and state laws and regulations regarding confidentiality including, but not limited to, 42 CFR Part 431, Subpart F, and Chapter 38 (§2.2-3800 et seq.) of Title 2.2 of the Code of Virginia. In no event shall the fiscal agent provide, grant, allow, or otherwise give, access to Medicaid information to anyone without the express written permission of the DMAS Director. The fiscal agent shall assume all liabilities under both state and federal law in the event that the information is disclosed in any manner.~~

~~2. Upon the fiscal agent receiving any requests for Medicaid information from any individual, entity, corporation, partnership or otherwise, the fiscal agent must notify DMAS of such requests within 24 hours. The fiscal agent shall ensure that there will be no disclosure of the data except through DMAS. DMAS will treat such requests in accordance with DMAS policies.~~

~~3. In cases where the information requested by outside sources can be released under the Freedom of Information Act (FOIA), as determined by DMAS, the fiscal agent shall provide support for copying and invoicing such documents.~~

~~D. A contract between the fiscal agent and the recipient or family or caregiver will be used to clearly express those aspects of the employment relationship that are to be handled by the fiscal agent, and which are to be handled by the recipient or family or caregiver. The contract will reflect that the fiscal agent is performing these tasks on behalf of the recipient or family or caregiver who is the actual employer of the attendant. Before the recipient begins receiving services, the fiscal agent will send the contract to the recipient or family or caregiver to review and sign. The fiscal agent must have a signed contract with the recipient or family or caregiver prior to the reimbursement of personal attendant services.~~

~~12VAC30-120-540. Recipient or family or caregiver responsibilities.~~ REPEALED.

~~A. The recipient or family or caregiver must be authorized for consumer-directed PAS and successfully complete management training performed by the service coordinator before the recipient or family or caregiver can hire a personal attendant.~~

~~B. The recipient or family or caregiver is the employer in this program and is responsible for hiring, training, supervising and firing personal attendants. Specific duties include checking references of personal attendants, determining that personal attendants meet basic qualifications, training personal attendants, supervising the personal attendants' performance, and submitting timesheets to the service coordinator and fiscal agent on a consistent and timely basis. The recipient or family or caregiver must have an emergency back-up plan in case the personal attendant does not show up for work as expected or terminates employment without prior notice.~~

~~C. The recipient or family or caregiver shall cooperate with the development of the plan of care with the service coordination provider, who monitors the plan of care and provides supportive services to the recipient. The recipient or family or caregiver shall also cooperate with the fiscal agent, who handles fiscal responsibilities on behalf of the recipient. Recipients or family or caregivers who do not cooperate with the service coordination provider and fiscal agent will be disenrolled from consumer-directed PAS.~~

~~D. Recipients or family or caregivers will acknowledge they will not knowingly continue to accept consumer-directed personal attendant services when the services are no longer appropriate or necessary for their care needs and will inform the service coordination provider.~~

~~12VAC30-120-550. DMAS termination of eligibility to receive home and community-based care services.~~ REPEALED.

~~A. DMAS shall have the ultimate responsibility for assuring appropriate placement of the recipient in home and community-based care services and the authority to terminate such services to the recipient for any of these reasons, but not necessarily limited to the provisions of this section.~~

~~B. Reasons eligibility for consumer-directed PAS may be terminated:~~

~~1. The home and community-based care service is not the critical alternative to prevent or delay institutional (nursing facility) placement.~~

~~2. The recipient no longer meets the nursing level of care for consumer-directed PAS or does not have family or a caregiver to direct his care.~~

~~3. The recipient's environment does not provide for his health, safety, and welfare.~~

~~4. An appropriate and cost-effective POC cannot be developed.~~

~~C. DMAS shall notify the recipient by letter. The effective date of termination shall be at least 10 days from the date of the termination notification letter. At the same time, DMAS will also advise the recipient in writing of his right to appeal the decision.~~

12VAC30-120-900. 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” or “ADLs” means tasks, e.g., 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 service needs.

“Americans with Disabilities Act or ADA” means the United States Code pursuant to § 42 U.S.C. 12101 et seq, as amended.

“Adult day health care center or ADHC” means a DMAS-enrolled provider that 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 disabled individuals at risk of placement in a nursing facility. The ADHC must be licensed by DSS as an ADHC.

“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.

“Agency-directed services” means services provided by a personal care agency.

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110-10 et seq. and 12VAC30-20-500 through 12VAC30-20-560.

"Barrier crime" means those crimes as defined at § 37.1-183.3 of the COV.

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

"Cognitive impairment" means a severe deficit in mental capability that affects an individual's areas of functioning such as thought processes, problem solving, judgment, memory, or comprehension which 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 individual or family/caregiver is responsible for hiring, training, supervising, and firing of the personal care aide.

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

"DMAS" means the Department of Medical Assistance Services.

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

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

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

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

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

"Fiscal agent" means an agency or division within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal care services and respite services.

"Home and community-based waiver services" or "waiver services" means the range of community support services approved by the CMS pursuant to § 1915(c) of the Social Security Act to be offered to persons who are elderly or disabled who would otherwise require the level of care provided in a nursing facility. DMAS or the designated preauthorization contractor shall only give preauthorization for medically necessary Medicaid reimbursed home and community care.

"Individual" means the person receiving the services established in these regulations.

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

"Medication monitoring" means an electronic device, that is only available in conjunction with Personal Emergency Response Systems, that enables certain individuals at high risk of institutionalization to be reminded to take their medications at the correct dosages and times.

"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 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 are provided to individuals in the areas of activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. Services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

"Personal care aide" means a person who provides personal care services.

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

"Personal emergency response system (PERS)" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals 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 provider" means a certified home health or a personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and services calls), and PERS monitoring. PERS providers may also provide medication monitoring.

"Plan of care" means the written plan developed by the provider related solely to the specific services required by the individual to ensure optimal health and safety while remaining in the community.

"Preadmission screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening; (ii) assist individuals in determining 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) refer individuals to the appropriate provider for Medicaid-funded nursing facility or home and community-based care for those individuals who meet nursing facility level of care.

"Preadmission Screening Committee/Team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to COV § 32.1-330.

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

"Respite services" means those short-term personal care services provided to individuals who are unable to care for themselves, because of the absence of or need for the relief of those unpaid caregivers who normally provide the care.

"State Plan for Medical Assistance" or "Plan" means the regulations identifying 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, that is completed by the Preadmission Screening Team, which assesses an individual's physical health, mental health, social, and functional abilities to determine if the individual meets the nursing facility level of care.

12VAC30-120-905. General coverage and requirements for Elderly or Disabled with Consumer-Direction waiver services.

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

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

2. Individuals who are disabled as defined by the Social Security Act § 1614.

B. Covered services.

1. Covered services shall include: adult day health care, personal care (both consumer- and agency-directed), respite services (both consumer-directed, agency-directed, and facility-based), and PERS.

2. These services shall be medically appropriate and medically necessary to maintain the individual in the community and prevent institutionalization.

3. A recipient of EDCD Waiver services may receive personal care (agency- and consumer-directed), respite care (agency- and consumer-directed), adult day health care, and PERS services in conjunction with hospice services, regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Services under this waiver will not be available to hospice recipients unless the hospice can document the provision of at least 21 hours per week of homemaker/home health aide services and that the recipient needs personal care-type services which exceed this amount.

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

12VAC30-120-920. Individual eligibility requirements.

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

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

2. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and §1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed below:

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

(1) An amount for the maintenance needs of the individual which is equal to the SSI income limit for one individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more per week,

earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) that is disregarded for maintenance exceed 300% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)

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

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

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

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

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

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

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

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

1. To ensure that Virginia's home and community-based waiver programs serve only Medicaid eligible individuals who would otherwise be placed in a nursing facility, home and community based waiver services shall be considered only for individuals who are eligible for admission to a nursing facility. Home and community-based waiver services shall be the critical service to enable the individual to remain at home and in the community rather than being placed in a nursing facility.

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

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

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

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

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

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

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

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

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

A. Requests for participation will be screened by DMAS or the designated DMAS contractor to determine whether the provider applicant meets these basic requirements for participation and demonstrates the abilities to perform, at a minimum, the following activities:

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

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

3. Assure the individual's freedom to refuse medical care, treatment, and services;

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

5. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC §2000 et seq.), which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§51.5-1 et seq. of the Code of Virginia); §504 of the Rehabilitation Act of 1973, as amended (29 USC §794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990, as amended (42 USC §12101 et seq.), which provides comprehensive

civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

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

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

8. Use only DMAS-designated forms for service documentation. The provider must not alter the DMAS forms in any manner unless approval from DMAS is obtained prior to using the altered forms.

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

10. Not perform any type of direct marketing activities to Medicaid individuals;

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

a. In general, 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. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and

every exception resolved. Records of minors shall be kept for 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 the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth.

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

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. Pursuant to 42 CFR 431.300, *et. seq.*, 12VAC30-20-90, and any other applicable federal or state law, all providers shall hold confidential and use for authorized DMAS purposes only all medical assistance information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits, or the data is necessary for the functioning of DMAS in conjunction with the cited laws;

15. Change of ownership. When ownership of the provider changes, DMAS shall be notified in writing at least 15 calendar days before the date of change;

16. Pursuant to §§63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based waiver services individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation must report this immediately from first knowledge to the local DSS adult or child protective services worker as applicable; and

17. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the applicable DMAS provider manual. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures may result in a retraction of Medicaid payment or termination of the provider agreement, or both.

18. Minimum qualifications of staff. All employees 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. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. DMAS will not reimburse the provider for any services provided by an employee who has committed a barrier crime as defined herein. Providers are responsible for complying with § 32.1-162.9:1 of the COV regarding criminal record checks.

B. For DMAS to approve provider agreements with home and community-based waiver providers, providers must meet staffing, financial solvency, disclosure of ownership, and assurance of comparability of services requirements as specified in the applicable provider manual.

C. The individual shall have the option of selecting the provider of his choice from among those providers who are approved and who can appropriately meet his needs.

D. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 day's written notification.

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

F. A provider shall have the right to appeal adverse actions taken by DMAS. Provider appeals shall be considered pursuant to 12 VAC 30-10-1000 and 12 VAC 30-20-500 through 12 VAC 30-20-560.

G. The Medicaid provider agreement shall terminate upon conviction of the provider of a felony pursuant to § 32.1-325 of the COV. A provider convicted of a felony in Virginia or in any other

of the 50 states, the District of Columbia or, the U.S. territories, must, within 30 days, notify the Virginia Medicaid Program of this conviction and relinquish the provider agreement.

H. It is the provider/service facilitator's responsibility for the Patient Information Form (DMAS-122). It shall be the responsibility of the service provider/service facilitator's provider to notify the designated preauthorization contractor and DMAS, in writing, when any of the following circumstances occur. Furthermore, it shall be the responsibility of the designated preauthorization contractor to update DMAS, as requested, when any of the following events occur:

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

2. An individual dies;

3. An individual is discharged from EDCD waiver services;

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

5. The initial selection by the individual or family/caregiver of a provider/service facilitator to provide services, or a change by the individual or family/caregiver of a provider/service facilitator, if it affects the individual's patient pay amount.

I. Changes or termination of services.

1. The provider may decrease the amount of authorized care if the revised plan of care is appropriate, and based on the needs of the individual. If the individual disagrees with the proposed decrease, the individual has the right to appeal to DMAS. The participating provider is responsible for developing the new plan of care and calculating the new hours of service delivery. The individual or person responsible for supervising the individual's care shall discuss the decrease in care with the individual or family/caregiver, document the conversation in the individual's record, and notify the designated preauthorization contractor and the individual or family of the change by letter. This letter shall clearly state to the individual's right to appeal.

2. If a change in the individual's condition necessitates an increase in care, the participating provider must 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 personal/respite care hours without approval from DMAS, or the designated preauthorization contractor, if the amount of services does not exceed the amount established by DMAS, or the designated preauthorization contractor, as the maximum for the level of care designated for that individual on the plan of care. Any increase to an individual's plan of care that exceeds the number of hours allowed for that individual's level of care or any change in the individual's level of care must be preauthorized by DMAS or the designated preauthorization contractor.

3. In an emergency situation when the health and safety of the individual or provider personnel is endangered, DMAS, or the designated preauthorization contractor, must be notified prior to discontinuing services. The written notification period shall not be required. If appropriate, the local DSS Adult or Child Protective Services must be notified immediately.

4. In a nonemergency situation, i.e. when the health and safety of the individual or provider personnel is not endangered, the participating provider, other than a PERS provider, shall give the individual or family/caregiver, or both, at least 10 days written notification plus three days for mailing of the intent to discontinue services. The notification letter shall provide the reasons for and the effective date the provider is discontinuing services. The effective date shall be at least 10 days plus three days for mailing from the date of the notification letter. A PERS provider shall give the individual or family/caregiver at least 14 days' prior written notification of the intent to discontinue services. The letter shall provide the reasons for and the effective date of the action. The effective date shall be at least 14 days from the date of the notification letter.

5. In the case of termination of home and community-based waiver services by DMAS or the designated preauthorization contractor, individuals shall be notified of their appeal rights pursuant to 12VAC30-110-10 et seq. DMAS, or the designated preauthorization contractor, has the responsibility and the authority to terminate the receipt of home and community-based care services by the individual for any of the following reasons:

a. The home and community-based care services are no longer the critical alternative to prevent or delay institutional placement;

b. The individual is no longer eligible for Medicaid;

c. The individual no longer meets the nursing facility criteria; or

d. The individual’s environment does not provide for his health, safety, and welfare.

J. DMAS will conduct annual level-of-care reviews for all waiver recipients.

12VAC30-120-950. Adult day health care services.

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

A. Adult day health care services may be offered to individuals in an ADHC setting. Adult day health care may be offered either as the sole home and community-based care service or in conjunction with personal care (agency- or consumer- directed), respite care (agency- or consumer-directed), or PERS.

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 DMAS for verification purposes prior to the applicant's enrollment as a Medicaid provider and shall be available for DMAS review;

2. Adhere to DSS adult day health care center standards;

3. The following DMAS special participation standards are imposed in addition to DSS standards and shall be met in order to provide Medicaid adult day health care services:

a. Provide a separate room or an area equipped with one bed, cot, or recliner for every 12 Medicaid adult day health care participants;

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

c. The center shall maintain a minimum staff-to-participant ratio of at least one staff member to every six participants. This includes Medicaid and other participants;

d. There shall be at least two staff members awake and on duty at the ADHC at all times when there are Medicaid participants in attendance;

e. In the absence of the director, the activities director, registered nurse, or therapist shall be designated to supervise the program;

f. Volunteers 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 so counted, there shall be at least one compensated employee included in the staff-to-participant ratio;

g. Any center that is co-located with another facility shall count only its own separate identifiable staff in the center's staff-to-participant ratio.

h. 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. The director shall be the provider contact person for DMAS and the designated preauthorization contractor, and shall be responsible for responding to communication from DMAS and the designated preauthorization contractor.

i. The director shall be responsible for assuring the development of the plan of care for adult day health care individuals. The director has ultimate responsibility for directing the center program and supervision of its employees. The director can also serve as the activities director if they meet the qualifications for that position.

ii. The director shall assign 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.

iii. The director shall meet the qualifications specified in the DSS standards for adult day health care for directors.

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

i. 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;

ii. 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.

(3) Program aides who shall be responsible for overall care and maintenance of the participant (assistance with activities of daily living, social/recreational activities, and other health and therapeutic related activities). Each program aide hired by the provider shall be screened to ensure compliance with qualifications required by DMAS. The aide shall, at a minimum, have the following qualifications:

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

ii. Be physically able to do the work;

iii. Have satisfactorily completed an educational curriculum related to the needs of the elderly and disabled. Acceptable curriculums 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 available for review by DMAS staff who are authorized by DMAS to review these files. Prior to assigning a program aide to a participant, the ADHC shall ensure that the aide has satisfactorily completed a DMAS-approved training program.

(4) Registered nurse (RN). The center shall employ or contract with a registered nurse who shall be responsible for administering to and monitoring the health needs of the participants. The nurse shall be responsible for the planning and implementation of the plan of care involving multiple services where specialized health care knowledge is needed. The nurse shall be present a minimum of eight hours each month at the center. 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 DMAS does not require that the registered nurse be a full-time staff position, there shall be a registered nurse available, either in person or by telephone, to the center's participants and staff during all times that the center is in operation. The registered nurse shall:

i. Be registered and licensed as a registered nurse to practice nursing in the Commonwealth;

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

C. Service responsibilities of the adult day health care center and staff shall be:

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.

2. RN responsibilities. The RN shall be responsible for:

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 or supervising the participant 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 center's fee for services but must be rendered as a separate service by a rehabilitative provider.

4. Nutrition responsibilities. The center shall provide one meal per day, which supplies one-third of the daily nutritional requirements established by the U.S. Department of Agriculture. Special diets and counseling shall be provided to Medicaid participants as necessary.

5. 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 and keep them updated, record 30-day progress notes, and review the participants' daily records each week. If the individual's condition changes more frequently, more frequent reviews and recording of progress notes shall be required to reflect the participant's changing condition.

6. Recreation and social activities responsibilities. The center shall provide planned recreational and social activities suited to the individuals' needs and designed to encourage physical exercise, prevent deterioration of the individual's condition, and stimulate social interaction.

D. Documentation required. The ADHC shall maintain all records of each Medicaid participant. These records shall be reviewed periodically by DMAS staff who are authorized by the DMAS to review these files. At a minimum, these records shall contain:

1. The Long-Term Care Uniform Assessment Instrument, the Medicaid Long-Term Care Services Authorization form (DMAS-96), the Screening Team Plan of Care or Medicaid-Funded Long-Term Care, the DMAS-101A and the DMAS-101B (if applicable), and the most recent patient information from the DMAS-122;

2. Interdisciplinary plans of care developed by the ADHC's director, registered nurse, or therapist and relevant support persons, in conjunction with the participant;

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 and make any necessary revisions;

4. At a minimum, 30-day goal oriented progress notes recorded by the designated 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 ADHC 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 records of services provided. The daily record shall contain the specific services delivered by ADHC staff. The record shall also contain the arrival and departure times of the participant and be signed weekly by the director, activities director, registered nurse, or therapist employed by the center. The daily record shall be completed on a daily basis, neither before nor after the date of services delivery. At least once a week, a staff member shall chart significant comments regarding care given to the participant. If the staff member writing comments is different from the staff signing the weekly record, that staff member shall sign the weekly comments. A copy of this record must be given to the participant or family/caregiver weekly; and

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

12VAC30-120-960. Agency-directed personal care services.

The following requirements govern the provision of agency-directed personal care services.

A. Service description. Personal care services are comprised of hands-on care of either a supportive or health-based nature and may include, but are not limited to, assistance with activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. This service does not include skilled nursing services with the exception of skilled nursing tasks (i.e., catheterization) that may be delegated pursuant to the Virginia Administrative Code at 18VAC90-20-420 through 18VAC90-20-460. It may be provided in a home and community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based care service or in conjunction with adult day health care, respite care (agency or consumer-directed), or PERS.

B. Criteria. In order to qualify for these services, the individual must demonstrate a need for care with activities of daily living.

1. DMAS will also pay, consistent with the approved plan of care, for personal care that the personal care aide provides to the enrolled individual to assist him at work or post-secondary school. 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.

2. DMAS or the designated preauthorization contractor will review the individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to him in the workplace or post-secondary school or both.

3. DMAS will not pay for the personal care aide to assist the enrolled individual with any functions related to the individual completing his job or post-secondary school functions or for supervision time during work or school or both.

4. There shall be a limit of 8 hours per 24-hour day for supervision services.

5. The provider must develop an individualized plan of care that addresses the individual's needs at home and work and in the community.

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

1. Operate from a business office;

2. Employees who 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 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 DMAS to review these files.

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

a. The registered nurse shall be currently licensed to practice in the Commonwealth as an RN 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, nursing facility, or as a licensed practical nurse (LPN)).

b. The registered nurse supervisor shall make an initial home assessment visit on or before the start of care for all individuals admitted to personal care, when an individual is readmitted after being discharged from services, or if he is transferred from another provider, ADHC, or from a consumer-directed services.

c. The registered nurse 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 individuals with a cognitive impairment and every 90 days for individuals who do not have a cognitive impairment, as defined herein. The provider agency shall have the responsibility of determining if 30-day registered nurse supervisory visits are appropriate for the individual.

(2) The initial home assessment visit by the registered nurse shall be conducted to create the plan of care and assess the individual's needs. The registered nurse shall return for a follow-up visit within 30 days after the initial visit to assess the individual's needs and make a final determination that there is no cognitive impairment. This determination must be documented in the individual's record by the registered nurse. Individuals 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 registered nurse may give the individual or family/caregiver the option of having the supervisory visit every 90 days or any increment in between, not to exceed 90 days, or the provider may choose to continue the 30-day supervisory visits based on the needs of the individual. The registered nurse supervisor must document in the individual's record this conversation and the option that was chosen. The individual or the family/caregiver must sign and date this document.

(4) If an individual's personal care aide is supervised by the provider's registered nurse supervisor less frequently than every 30 days and DMAS, or the designated preauthorization contractor, determines that the individual’s health, safety, or welfare is in jeopardy, DMAS, or the designated preauthorization contractor, may require the provider's registered nurse supervisor to supervise the personal care aide every 30 days or more frequently than has been determined by the registered nurse supervisor. This will be documented by the provider and entered in the individual's record.

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

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

(2) Whether the plan of care is adequate to meet the individual's needs or if changes are indicated in the plan;

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

(4) The individual's satisfaction with the services;

(5) Whether the individual has been hospitalized or there has been a change in the medical condition or functional status of the individual;

(6) Other services received by the individual and the amount; and

(7) The presence or absence of the personal care aide in the home during the registered nurse supervisor's visit.

e. A registered nurse supervisor shall be available to the personal care aide for conferences 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 individuals.

f. The registered nurse supervisor shall evaluate the personal care aide's performance and the individual’s needs to identify any insufficiencies in the personal care aide's abilities to function competently and shall provide training as indicated. This shall be documented in the individual's record.

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

3. Employ and directly supervise personal care aides who provide direct care to individuals. Each aide hired for personal care shall be evaluated by the provider agency to ensure compliance with qualifications required by DMAS. Each personal care 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 an individual, the provider agency shall ensure that the personal care aide has satisfactorily completed a DMAS-approved training program consistent with DMAS standards;

c. Be physically able to do the work;

d. Not be: (i) the parents of minor children who are receiving waiver services or (ii) spouses of individuals who are receiving waiver services; and

e. 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 or aides available to provide the care. These family members must meet the same requirements as personal care aides who are not family members.

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

1. The most recently updated Long-Term Care Uniform Assessment Instrument, the Medicaid-Funded Long-Term Care Services Authorization form (DMAS-96), the Screening Team Plan of Care for Medicaid-Funded Long-Term Care (DMAS-97), all provider plans of care (DMAS97-A), all Patient Information forms (DMAS-122), and all DMAS-101A and 101B forms (if applicable).

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

3. Registered nurse supervisor’s notes recorded and dated during significant contacts with the personal care aide and during supervisory visits to the individual's home;

4. All correspondence to the individual, DMAS, and the designated preauthorization contractor;

5. Reassessments made during the provision of services;

6. Significant contacts made with family/caregivers, physicians, DMAS, the designated preauthorization contractor, formal, informal services providers and all professionals related to the individual's Medicaid services or medical care;

7. All personal care aides' records (DMAS-90). The personal care aide record shall contain:

a. The specific services delivered to the individual by the aide and his responses to this service;

b. The personal care aide's daily arrival and departure times;

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

d. The personal care aide's and individual's or responsible caregiver's weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the individual unless he is a family/caregiver of the individual. This family member cannot be the same family member who is providing the service. Signatures, times and dates shall not be placed on the personal care aide record prior to the last date that the services are actually delivered; and

8. All of the individual's progress reports.

12VAC30-120-970. Agency-directed respite care services.

These requirements govern the provision of agency-directed respite care services.

A. Agency-directed respite care services are comprised of hands-on care of either a supportive or health-related nature and may include, but are not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medications or other medical needs, monitoring health status and physical condition, and personal care services provided in a work environment. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. This service does not include skilled nursing services with the exception of skilled nursing tasks (i.e., catheterization) that may be delegated pursuant to the Virginia Administrative Code at 18VAC90-20-420 through 18VAC90-20-460.

B. General. 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. Respite care services may be provided in the individual's home or place of residence, or a facility licensed as a nursing facility and enrolled in Medicaid. The authorization of respite care (agency-directed and consumer-directed) is limited to a total of 720 hours per calendar year per individual. Reimbursement shall be made on an hourly basis.

C. Special provider participation conditions. To be approved as a respite care provider with DMAS, the respite care provider shall:

1. Operate from a business office.

2. Have employees who have satisfactory work records, as evidenced by 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 COV 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. DMAS will not reimburse the provider for any services provided by an employee who has committed a barrier crime.

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

a. The registered nurse supervisor shall be currently licensed to practice in the Commonwealth as an RN 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, nursing facility, or as an LPN).

b. Based on continuing evaluations of the aide's/LPN's performance and the individual's needs, the registered nurse supervisor shall identify any insufficiencies in the aide's/LPN's abilities to function competently and shall provide training as indicated.

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

d. A registered nurse 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 supervisory visits shall be every 30 to 90 days dependent on the cognitive status of the individual. If an individual is also receiving personal care services, the respite care RN supervisory visit may coincide with the personal care RN supervisory visits.

(2) When respite care services are not received on a routine basis, but are episodic in nature, a registered nurse supervisor shall not be required to conduct a supervisory visit every 30 to 90 days. Instead, a registered nurse supervisor shall conduct the initial home assessment visit with the aide/LPN on or before the start of care and make a second home visit during the second respite care visit. If an individual is also receiving personal care services, the respite care RN supervisory visit may coincide with the personal care RN supervisory visit.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the RN 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 individual record can be used with a separate section for respite care documentation.

e. During visits to the individual's home, the registered nurse supervisor shall observe, evaluate, and document the adequacy and appropriateness of respite care services with regard to the individual's current functioning status, medical, and social needs. The aide's/LPN's record shall be reviewed along with the individual's or family's satisfaction with the type and amount of services discussed. The registered nurse supervisor 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 individual's needs or if changes need to be made to the plan of care;

(3) The individual's satisfaction with the services;

(4) Any hospitalization or change in the medical condition or functioning status of the individual;

(5) Other services received by the individual and the amount of the services received; and

(6) The presence or absence of the aide/LPN in the home during the RN supervisory visit.

f. An RN supervisor shall be available to the aide/LPN for conference pertaining to individuals being served by the aide/LPN and shall be available to the aide/LPN by telephone at all times that the aide/LPN is providing services to respite care individuals.

g. If there is a delay in the registered nurse's supervisory visits, because the individual is unavailable, the reason for the delay must be documented in the individual's record.

4. Employ and directly supervise aides/LPNs who provide direct care to respite care individuals. Each aide/LPN hired by the provider shall be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Each aide must:

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

b. Be physically able to do the work;

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

d. Have completed a minimum of 40 hours of DMAS-approved training consistent with DMAS standards. Prior to assigning an aide to an individual, the provider shall ensure that the aides has satisfactorily completed a training program consistent with DMAS standards;

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

f. Respite care aides 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 members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers or aides available to provide the care. Family members who are approved to provide paid respite services must meet the qualifications for respite care aides.

5. Employ a licensed practical nurse (LPN) to perform skilled respite care services. Such services shall be reimbursed by DMAS under the following circumstances:

a. The individual 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 (e.g., individuals on a ventilator, individuals requiring nasogastric, or gastrostomy feedings, etc.);

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

c. The individual is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver; and

d. The provider must document in the individual's record the circumstances which require the provision of services by an LPN.

e. When an LPN is required, the LPN must also provide any of the services normally provided by an aide.

D. Required documentation for individuals' records. The provider shall maintain all records of each individual receiving respite services. These records shall be separated 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 DMAS to review these files. At a minimum these records shall contain:

1. The most recently updated Long-Term Care Uniform Assessment Instrument, the Medicaid-Funded Long-Term Care Services Authorization form (DMAS-96), the Screening Team Plan of Care for Medicaid-Funded Long-Term Care (DMAS-97), all respite care assessments and plans

of care, all aide records (DMAS-90), all LPN skilled respite records (DMAS-90A), all Patient Information forms (DMAS-122) and all DMAS-101A and DMAS-101B forms, as applicable;

2. The physician’s order for services, obtained prior to the service begin date and updated every six months.

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

4. Registered nurse supervisor’s notes recorded and dated during significant contacts with the care aide and during supervisory visits to the individual's home;

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

6. Reassessments made during the provision of services;

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

8. All respite care records. The respite care record shall contain:

a. The specific services delivered to the individual by the aide or LPN, and his response to this service;

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

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

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

(e) Documentation signed by the LPN must be reviewed and signed by the supervising RN.

(f). All individual progress reports.

12VAC30-120-980. Personal emergency response system (PERS).

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

B. 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 manual reset by the recipient.

C. Criteria. PERS services are limited to those individuals, 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 (agency or consumer-directed), respite (agency or consumer-directed), or adult day health care. An individual may not receive PERS if he has a cognitive impairment as defined in 12VAC30-120-900.

1. PERS can be authorized when there is no one else, other than the individual, in the home who is competent and continuously available to call for help in an emergency. If the individual'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 individual is evaluated as being dependent in the categories of "Behavior Pattern" and "Orientation" on the Uniform Assessment Instrument (UAI).

2. Medication monitoring units must be physician ordered. In order to receive medication monitoring services, an individual must also receive PERS services. The physician orders must be maintained in the individual's file.

D. Services units and services limitations.

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

2. PERS service must be capable of being activated by a remote wireless device and be connected to the individual'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, 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 individual.

3. 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. There must be documentation of this in the individual's record.

E. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver participating providers as specified in 12VAC30-120-930, PERS providers must also meet the following qualifications:

1. A PERS provider must be either a personal care agency, a durable medical equipment provider, a hospital, a licensed home health provider, or a PERS manufacturer. All such providers shall have the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring;

2. The PERS provider must provide an emergency response center with fully trained operators who are capable of receiving signals for help from an individual'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 individual 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 individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit, and shall provide temporary equipment while the original equipment is being repaired;

5. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line within seven days of the request unless there is appropriate documentation of why this timeframe cannot 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 individual at no additional cost to DMAS or the individual. The record must document all of the following:

a. Delivery date and installation date of the PERS;

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

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

d. Updated and current individual responder and contact information, as provided by the individual or the individual's caregiver; and

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

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

9. 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 Safety Standard Number 1637 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 individual;

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

11. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by individuals 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 individual'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 individual resetting the system in the event it cannot get its signal accepted at the response center;

12. PERS providers 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 PERS provider must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment. The PERS provider'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 individual'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 PERS provider 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 that results in action being taken on behalf of the individual. This excludes test signals or activations made in error. This written report shall be furnished to the personal care provider, the respite care provider, the CD services facilitation provider, or in cases where the individual only receives ADHC services, to the ADHC provider;

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

16. The PERS provider must obtain and keep on file a copy of the most recently completed Patient Information form (DMAS-122). Until the PERS provider obtains a copy of the DMAS-122, the PERS provider must clearly document efforts to obtain the completed DMAS-122 from the personal care, respite care, CD services facilitation provider, or the ADHC provider.

12VAC 30-120-990. Consumer-directed services: personal care and respite services.

A. Service description.

1. Consumer-directed personal care services and respite care services are comprised of hands-on care of either a supportive or health-related nature and may include, but are not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medications or other medical needs, monitoring health status and physical condition, and personal care services provided in a work environment. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. This service does not include skilled nursing services with the exception of skilled nursing tasks (i.e., catheterization) that may be delegated pursuant to the Virginia Administrative Code at 18VAC90-20-420 through 18VAC90-20-460.

2. Consumer-directed respite services are specifically designed to provide temporary, periodic, or routine relief to the unpaid, live-in, primary caregiver of an individual. 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 services. The fiscal agent will be reimbursed by DMAS (if the service is contracted) 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 Service Facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed services. The CD Service Facilitator is 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, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the aide.

B. Criteria.

1. In order to qualify for consumer-directed personal care services, the individual must demonstrate a need for personal care services as defined in 12 VAC30-120-900.

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

3. DMAS will also pay, consistent with the approved plan of care, for personal care that the personal care aide provides to the enrolled individual to assist him at work or post-secondary school. 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.

a. DMAS or the designated preauthorization contractor will review the individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to him in the workplace or post-secondary school or both.

b. DMAS will not pay for the personal care aide to assist the enrolled individual with any functions related to the individual completing his job or post-secondary school functions or for supervision time during work or school or both.

4. Individuals who are eligible for consumer-directed services must have, or have a family/caregiver who has, the capability to hire and train their own personal care aides and supervise the aide'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.

5. The individual, or if the individual is unable, a family/caregiver, shall be the employer of consumer-directed services and therefore shall be responsible for hiring, training, supervising, and firing personal care aides. Specific employer duties include checking of references of personal care aides, determining that personal care aides meet basic qualifications, and maintains copies of timesheets to have available for review by the CD service facilitator and the fiscal

agent on a consistent and timely basis. The individual or family/caregiver must have a back-up plan for the provision of services in case the aide does not show up for work as expected or terminates employment without prior notice.

C. Service units and limitations.

1. The unit of services 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 services, agency-directed respite services and/or facility-based respite services, may not receive more than 720 hours combined, regardless of service delivery method.

2. The unit of service for consumer-directed personal care services is one hour.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC 30-120-930, 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 fully and accurately document the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess, at a minimum, an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator have at least two years of satisfactory experience in a human services field working with individuals who are disabled or elderly. 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 CD services facilitator's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in individuals who are elderly or individuals with disabilities, as well as strategies to reduce limitations and health problems;

(2) Physical care that may be required by individuals who are elderly or individuals with disabilities, 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 individuals who are elderly or individuals with disabilities that reduce 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 care and respite services;

(5) Elderly or Disabled with Consumer-Direction waiver requirements, as well as the administrative duties for which the service facilitator will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in services planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets, and firing an aide;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals, family/caregivers and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals who are elderly or individuals with disabilities; and

(4) Identifying services within the established services system to meet the individual's needs;

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing; and

(6) Develop a rapport and communicate with individuals from diverse cultural backgrounds.

3. If the CD services facilitator is not a registered nurse, the CD services facilitator must inform the individual's primary health care provider that services are being provided and 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 within seven days of the initial visit. The initial comprehensive home visit is done only once per provider upon the individual's entry into CD services. If the 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 plan of care on an as-needed basis, but in no event less frequently than quarterly for personal care. 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 CD services facilitator must conduct face-to-face meetings with the individual or family/caregiver at least every six months for respite services and quarterly for personal care to ensure appropriateness of any consumer-directed 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 aide and the aide'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 aide in the home during the CD services facilitator's visit.

6. The CD services facilitator must be available to the individual or family/caregiver by telephone.

7. The CD services facilitator must request a criminal record check and a sex offender record check pertaining to the aide on behalf of the individual and report findings of these records checks to the individual or the family/caregiver and the program's fiscal agent. If the individual is a minor, the aide must also be screened through the DSS Child Protective Services Central Registry (The criminal record check and DSS Child Protective Services Registry finding must be requested by the CD services facilitator prior to beginning CD services). Aides will not be reimbursed for services provided to the individual effective the date that the criminal record check confirms an aide has been found to have been convicted of a crime as described in §37.1-

183.3 of the COV or if the aide has a confirmed record on the DSS Child Protective Services Registry..

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

9. 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.

b. The personal care plan of care goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, and modified as appropriate. Respite plan of care goals, objectives, and activities must be reviewed by the provider annually and every six months or when 300 service hours have been used. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual.

c. CD services facilitator’s dated notes documenting any contacts with the individual, family/caregiver, and visits to the individual’s home;

d. All correspondence to and from the individual, the designated preauthorization contractor, and DMAS;

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

f. All training provided to the aides on behalf of the individual or family/caregiver;

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

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

i. All copies of the completed Uniform Assessment Instrument (UAI), the Long-Term Care Preadmission Screening Authorization (DMAS-96), the Screening Team Plan of Care (DMAS-97B), all Consumer-Directed Personal Assistance Plans of Care (DMAS-97B), all Patient Information Forms (DMAS-122), the DMAS-95 Addendum, the Outline and Checklist for Consumer-Directed Recipient Comprehensive Training, and the Services Agreement Between the Consumer and the Services Facilitator.

10. For consumer-directed personal care and consumer-directed respite services, individuals or family/caregivers will hire their own personal care aides and manage and supervise their performance. The aide 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 supporting documentation;

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

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 aide will not be compensated for services provided to the individual if either of these records checks verifies the aide has been convicted of crimes described in §37.1-183.3 of the COV or if the aide 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 Elderly or Disabled with Consumer Direction waiver requirements; and

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

11. Aides may not be the parents of individuals who are minors or the individuals' spouses or the family/caregivers that are directing the individual's care. 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.

12. Family/caregivers who are reimbursed to provide consumer-directed services must meet the aide qualifications.

13. If the individual is consistently unable to hire and retain the employment of a personal care aide to provide consumer-directed personal care or respite services, the CD services facilitator will make arrangements to have the services transferred to an agency-directed services provider, of the individual's choice, or to discuss with the individual or family/caregiver other service options.

14. The CD services facilitator is required to submit to DMAS biannually, for every individual, an individual progress report, the most recently updated UAI, and any monthly visit/progress reports. This information is used to assess the individual's ongoing need for Medicaid-funded long-term care and appropriateness and adequacy of services rendered.

D. Individual responsibilities.

1. The individual must be authorized for consumer-directed services and successfully complete management training performed by the CD services facilitator before the individual can hire a personal care aide for Medicaid reimbursement. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal care aides and supervise aides' performance. Individuals with cognitive impairments who are unable to manage

their own care may have a family/caregiver person may serve as the employer on behalf of the individual.

2. Individuals will acknowledge that they will not knowingly continue to accept consumer-directed personal care services when the service is no longer appropriate or necessary for their care needs and will inform the services facilitator. If consumer-directed services continue after services have been terminated by DMAS or the designated preauthorization contractor, the individual will be held liable for employee compensation.