12VAC30-120-10. Definitions.

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

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

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

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

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

"DMAS" means the Department of Medical Assistance Services.

"DSS" means the Department of Social Services.

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

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

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

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

"Nursing Home Preadmission Screening Committee/Team" means the entity contracted with the DMAS which 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 must 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.

"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.

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

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

"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 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.

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

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

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

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

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

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

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

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

A. Coverage statement.

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

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

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

B. Patient qualification and eligibility requirements.

1. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy and the medically needy. Virginia has elected to cover the optional categorically needy group under 42 CFR 435.211, 435.231 and 435.217. The income level used for 435.211, 435.231 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

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.

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.

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

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

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

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

3. An essential part of the Nursing Home Preadmission Screening 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 process.

4. 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 plan of care and initiate referrals for service.

5. Reserved.

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

7. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by the Nursing Home Preadmission Screening Committee/Team.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Staffing requirements,
2. Financial solvency,
3. Disclosure of ownership, and
4. Assurance of comparability of services.

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

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

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

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

1. The reconsideration process shall consist of three phases:

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

b. The informal conference, and

c. The formal evidentiary hearing.

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

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

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

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

2. A recipient dies,

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

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

I. Changes or termination of care.

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

a. The provider agency may decrease the amount of authorized care only if the recipient and the participating provider both agree that a decrease in care is needed and that the amount of care in the revised plan of care is appropriate.

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, or both, document the conversation in the recipient's record, and shall notify the recipient or family of the change by letter.

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

2. Increases in amount of authorized care. If a change in the recipient's condition (physical, mental, or social) necessitates an increase in care, the participating provider shall assess the need for increase and, if appropriate, develop a plan of care for services to meet the changed needs. The provider may implement the increase in hours without approval from DMAS 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 preapproved by the DMAS utilization review analyst assigned to the provider.

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

4. Emergency termination of home and community-based care services by the participating provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered the DMAS must be notified prior to termination. The five-day written notification period shall not be required.

5. DMAS 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 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.

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

J. Suspected abuse or neglect. Pursuant to § 63.1-55.3 of the Code of Virginia, if a participating provider agency knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse/neglect/exploitation shall report this to the local DSS.

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

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

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

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

community-based care service and authorize the service if it is deemed necessary to avoid institutionalization.

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

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

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

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

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

The following staff are required by DMAS:

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

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

c. In the absence of the director, a professional staff member shall be designated to supervise the program.

d. Volunteers shall be included in the staff ratio only when they conform to the same standards and requirements as paid staff and meet the job description standards of the organization.

e. Any center that is collocated with another facility shall count only its own separate identifiable staff in the center's staff/participant 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 staff and shall be responsible for contracting, and receipt and response to communication from DMAS. The director shall be responsible for assuring the initial 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 serve as activities director also if those qualifications are met.

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

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

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

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

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

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

a. Be able to read and write.

b. Be physically able to do the work.

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

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. 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 the DMAS staff. Training consistent with DMAS training guidelines may also be given by the center's professional staff. The content of the training shall be approved by DMAS prior to assignment of the aide to a Medicaid participant.

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, rehabilitation hospital, or nursing facility).

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

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.

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

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

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 adult day care center, or supervising the individual in self-administered medication.

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

4. Transportation responsibilities. Every DMAS approved adult day health care center shall provide transportation when needed in emergency situations (i.e., primary caregiver has an accident and cannot transport the participant home) for all Medicaid participants to and from their homes. Any adult day health care center which is able to provide participants with transportation routinely to and from the center can be reimbursed by DMAS based on a per trip (to and from the participant's residence) fee. This reimbursement for transportation shall be preauthorized by either the Nursing Home Preadmission Screening Team or DMAS utilization review staff.

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

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

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

E. Documentation required. The adult day health care center shall maintain all records of each Medicaid participant. These records shall be reviewed periodically by DMAS staff. At a minimum, these records shall contain:

1. Long-term care Information Assessment Instrument, the Nursing Home Preadmission Screening Authorization, and the Screening Team Plan of Care.

2. Interdisciplinary Plan of Care developed by adult day health care center professional staff and the participant and relevant support persons.

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

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

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

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

7. All correspondence to the participant and to DMAS.

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

12VAC30-120-50. Personal care services.

The following requirements govern the provision of personal care services.

A. General. Personal care services may be offered to individuals in their homes as an alternative to more costly institutional care. Personal care may be offered either as the sole home and community-based care service that avoids institutionalization or in conjunction with adult day

health care ~~or~~ , respite care, ~~or both~~ , or PERS. When the individual referred for personal care is already receiving another home and community-based care service, the DMAS utilization review staff shall assess the need for the additional home and community-based care service and authorize the service if it is deemed necessary to avoid institutionalization.

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

1. Demonstrate a prior successful health care delivery.

2. Operate from a business office.

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

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

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

c. The RN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. A minimum frequency of these visits is every 30 days.

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

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

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

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

(4) Recipient's satisfaction with the service,

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

(6) Other services received and their amount, and

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

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

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

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

a. Be able to read and write.

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

c. Be physically able to do the work.

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

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

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

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

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

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

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

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

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

D. Required documentation in recipients' records. The provider agency shall maintain all records of each personal care recipient. At a minimum these records shall contain:

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

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

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

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

5. All correspondence to the recipient and to DMAS.

6. Reassessments made during the provision of services.

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

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

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

b. The aide's arrival and departure times,

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

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

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.

9. All recipient progress reports.

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

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

The following requirements govern the provision of PERS services:

A. Service Description. PERS is a service which electronically monitors recipient safety in the home and provides access to emergency crisis intervention 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.

B. Criteria. 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 a day care center, PERS will only be approved if the recipient is evaluated as being dependent in orientation and behavior pattern.

C. Service units and service limitations.

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

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 staff 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 as appropriate, days per year; 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 and 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 or activating devices, 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 and must furnish all supplies necessary to ensure that the system is installed and working properly.

6. The PERS installation includes 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 all installed PERS equipment in proper working order.

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

a. Delivery date and installation date of the PERS;

b. Enrollee/caregiver signature verifying receipt of PERS device;

c. Verification by a test that the PERS device is operational, monthly or more frequently as 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 recipient system utilization and recipient or responder contacts and communications.

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

10. 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.

11. A PERS provider must furnish education, data, and ongoing assistance to DMAS 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.

12. 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.

13. 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 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.

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

15. The PERS provider shall document and furnish 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, or in cases where the recipient only receives ADHC services, to the ADHC provider.

16. The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid recipients.

12VAC30-120-60. Respite care services.

These requirements govern the provision of respite care services.

A. General. Respite care services may be offered to individuals in their homes as an alternative to more costly institutional care. Respite care is distinguished from other services in the continuum of long-term care because it is specifically designed to focus on the need of the caregiver for temporary relief. Respite care may only be offered to individuals who have a primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. The authorization of respite care is limited to 30 24-hour days over a 12-month period. Reimbursement shall be made on an hourly basis for any amount authorized up to eight hours within a 24-hour period. Any amount over an eight-hour day will be reimbursed on a per diem basis. The option of respite care may be offered either as a secondary home and community-based care service to those individuals who receive either personal care ~~or~~ , adult day health care , or PERS or as the sole home and community-based care service received in lieu of nursing facility placement.

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

1. Demonstrate a prior successful health care delivery.
2. Operate from a business office.
3. Employ (or subcontract with) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all respite care aides.

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

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

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

d. The RN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

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

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

(3) When respite care services are routine in nature and offered in conjunction with personal care, the 30-day supervisory visit conducted for personal care may serve as the RN visit for respite care. However, the RN supervisor shall document supervision of respite care separately. For this purpose, the same recipient record can be used with a separate section for respite care documentation.

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

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

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

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

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

(5) Other services received and their amount, and

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

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

g. The RN providing supervision to respite care aides shall be available to them by telephone at all times that services are being provided to respite care recipients. Any lapse in RN coverage shall be reported immediately to DMAS.

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

a. Be able to read and write.

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

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

d. Have the physical ability to do the work.

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

f. Not be a member of a recipient's family (e.g., family is defined as parents, spouses, siblings, grandparents, and grandchildren).

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

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

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

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

d. The agency can document the circumstances which require the provision of services by an LPN.

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

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

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

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

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

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

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

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

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

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

1. Long-Term Care Assessment Instrument, the Nursing Home Preadmission Screening Authorization, all Respite Care Assessment and Plans of Care, and all DMAS-122's.

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

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

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

5. All correspondence to the recipient and to DMAS.

6. Reassessments made during the provision of services.

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

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

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

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

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

d. The signature by the aide or LPN, and the recipient once each week to verify that respite care services have been rendered. Signature, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

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

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

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

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

2. The primary home and community-based care services offered to the individual are determined to be insufficient to prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent individual.

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