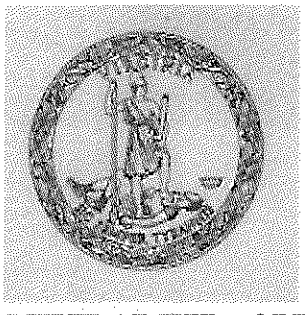

COMMONWEALTH of VIRGINIA

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TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **USHA KODURU** UK
Assistant Attorney General

DATE: **November 27, 2013**

SUBJECT: **Final regulations to amend the Elderly or Disabled with Consumer Direction Waiver program.**

I reviewed the attached Final regulations that contain comprehensive changes to the EDCD Waiver program. You asked this office to review and determine if DMAS has the legal authority to amend these regulations and if the proposed amendments comport with state and federal law.

Virginia Code §§ 32.1-324 and 32.1-325 grant to the Board of Medical Assistance Services the authority to administer and amend the plan for Medical Assistance and authorizes the Director of DMAS to take action according to the Board's requirements. The specific authority for these changes derives from §§ 1902 (a) and 1915(c) of the Social Security Act.

If you have any questions or need any additional information, please call me at 786-4074.

Attachments

cc: Kim F. Piner
Senior Assistant Attorney General/Section Chief

Final Text

Action: Elderly or Disabled with Consumer Direction Waiver Updates

Stage: Final 11/21/13 1:52 PM [latest]

12VAC30-120-900
Part IX
Elderly or Disabled with Consumer Direction Waiver

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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:

[~~"Abuse" means, for the purposes of this waiver, the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse, or exploitation of any person. Types of abuse include (i) physical abuse (a physical act by a person that may cause physical injury to an individual); (ii) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade, or demean an individual); (iii) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation, sexual harassment, or inappropriate or unwanted touching of an individual, or any or all of these); and (iv) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate an individual).~~]

"Activities of daily living" or "ADLs" means personal care tasks such as 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.

"Adult day health care ~~center~~" or "ADHC" means ~~a DMAS-enrolled provider that offers~~ long-term maintenance or supportive services offered by a DMAS-enrolled community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those ~~elderly and disabled~~ waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility. The ~~ADHC must~~ program shall be licensed by ~~DSS~~ the Virginia Department of Social Services (VDSS) as an ~~ADHC~~ adult day care center (ADCC). The services offered by the center shall be required by the waiver individual in order to permit the individual to remain in his home rather than entering a nursing facility. ADHC can also refer to the center where this service is provided.

~~"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 model of services" means ~~services provided by a personal care agency~~ a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes for personal and respite care.

"Americans with Disabilities Act" or "ADA" means the United States Code pursuant to 42 USC § 12101 et seq.

"Annually" means a period of time covering 365 consecutive calendar days or 366 consecutive days in the case of leap years.

"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.

"Assistive technology" [or "AT"] means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable waiver individuals who are participating in the Money Follows the Person demonstration program pursuant to 12VAC30-120-2000 [et seq.] to increase their abilities to perform activities of daily living~~,~~ or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment. ~~12VAC30-120-762 provides the service description, criteria, service units and limitations, and provider requirements for this service. This service shall be available only to those EDCD waiver enrollees who are participants in the Money Follows the Person demonstration.~~

"Barrier crime" means those crimes as defined at §§ 32.1-162.9:1 [~~and 63.2-1719~~] of the Code of Virginia that would prohibit the continuation of employment if a person is found through a Virginia State Police criminal record check to have been convicted of such a crime.

"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~~ a waiver individual's areas of functioning such as thought processes, problem solving, judgment, memory, or comprehension that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

~~"Consumer-directed services" means services for which the individual or family/caregiver is responsible for hiring, training, supervising, and firing of the personal care aide.~~

"Conservator" means a person appointed by a court to manage the estate and financial affairs of an incapacitated individual.

"Consumer-directed (CD) model of services" means the model of service delivery for which the waiver individual or the individual's employer of record, as appropriate, are responsible for hiring, training, supervising, and firing of the person or persons who actually render the services that are reimbursed by DMAS.

~~"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.~~

"Day" means, for the purposes of reimbursement, a 24-hour period beginning at 12:00 a.m. and ending at 11:59 p.m.

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

"Direct marketing" means ~~either~~ any of the following: (i) conducting either directly

or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) using 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) providing 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.

"DBHDS" means the Department of Behavioral Health and Developmental 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.~~

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

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer-directed model of service delivery. The EOR may be [the individual enrolled in the waiver,] a family member [, ~~or~~] caregiver [or another person] [~~, as appropriate , when the waiver individual is unwilling or unable to perform the employer functions~~].

"Environmental modifications" [or "EM"] means physical adaptations to ~~a house, place of residence,~~ an individual's primary home or primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 1201 et seq.), [~~and~~] which are necessary to ensure the ~~individuals'~~ individual's [~~waiver~~] health and safety or enable functioning with greater independence ~~when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals. 12VAC30-120-758 provides the service description, criteria, service units and limitations, and provider requirements for this service. This service shall be available only to those EDCD waiver enrollees who are participants in the Money Follows the Person demonstration~~ and shall be of direct medical or remedial benefit to individuals who are participating in the Money Follows the Person demonstration program pursuant to 12VAC30-120-2000 [et seq.]. Such physical adaptations shall not be authorized for Medicaid payment when the adaptation is being used to bring a substandard dwelling up to minimum habitation standards.

~~"Fiscal agent" means an agency or division within DMAS or entity 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.~~

"Fiscal/employer agent" means a state agency or other entity as determined by DMAS that meets the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act, § 2.2-4300 et seq. of the Code of Virginia.

"Guardian" means a person appointed by a court to manage the personal affairs of an incapacitated individual pursuant to § 64.2-2000 et seq. of the Code of Virginia

[~~, including responsibility for making decisions regarding the waiver individual's support, care, health, safety, habilitation, education, therapeutic treatment, and residence~~] .

"~~Health~~, safety, and welfare standard" means, for the purposes of this waiver, that an individual's right to receive an EDCD Waiver service is dependent on a determination that the waiver individual needs the service based on appropriate assessment criteria and a written plan of care [, including having a backup plan of care,] that demonstrates medical necessity and that services can be safely provided in the community or through the model of care selected by the individual.

"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~~ individuals as an alternative to institutionalization.

"Individual" means the person ~~receiving the services established in these regulations~~ who has applied for and been approved to receive these waiver services.

"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.

"Level of care" or "LOC" means the specification of the minimum amount of assistance an individual [~~must require~~ requires] in order to receive services in an institutional setting under the State Plan or to receive waiver services.

"License" means proof of official or legal permission issued by the government for an entity or person to perform an activity or service such that, in the absence of an official license, the entity or person is debarred from performing the activity or service.

"Licensed Practical Nurse" or "LPN" means a person who is licensed or holds multi-state licensure [to practice nursing] pursuant to § 54.1-3000 et seq. of the Code of Virginia [~~to practice nursing~~] .

"Live-in caregiver" means a personal caregiver who resides in the same household as the [~~waiver~~] individual who is receiving waiver services.

"Long-term care" or "LTC" means a variety of services that help individuals with health or personal care needs and activities of daily living over a period of time. Long-term care can be provided in the home, in the community, or in various types of facilities, including nursing facilities and assisted living facilities.

[~~"Medication administration" means the direct administration of medications by injection, inhalation, or ingestion or any other means to a waiver individual by either (i) the waiver individual or (ii) persons legally permitted to administer medications. ~~]

"Medicaid Long-Term Care (LTC) Communication Form" or "DMAS-225" means the form used by the long-term care provider to report information about changes in an individual's eligibility and financial circumstances.

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

"Money Follows the Person" or "MFP" means the [demonstration] program [~~of transition services~~], as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

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

"Patient pay amount" means the portion of the [~~long-term care~~] individual's income that must be paid as his share of the long-term care services and is calculated by the local department of social services based on the individual's documented monthly income and permitted deductions.

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

"Personal care aide" or "aide" means a person employed by an agency who provides personal care or unskilled respite services. The aide shall have successfully completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities as further set out in 12VAC30-120-935. Such successful completion may be evidenced by the existence of a certificate of completion, which is provided to DMAS during provider audits, issued by the training entity.

"Personal care attendant" or "attendant" means a person who provides personal care or respite services that are directed by a consumer, family member/caregiver, or employer of record under the CD model of service delivery.

"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~~ a range of support services necessary to enable the waiver individual to remain at or return home rather than enter a nursing facility and that includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care services shall be provided by aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model or by personal care attendants under the CD model of service delivery.

"Personal emergency response system (PERS)" means an electronic device and monitoring service that enable certain waiver individuals, who are at least 14 years of age, at ~~high~~ risk of institutionalization to secure help in an emergency. PERS services ~~are~~ shall be limited to those waiver individuals who live alone or who 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~~ responsibility to ~~provide~~ furnish, install, maintain, test, monitor, and service 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" or "POC" means the written plan developed ~~by~~ collaboratively by the waiver individual and the waiver individual's family/caregiver, as appropriate, and the provider related solely to the specific services ~~required by~~ necessary for the individual ~~to ensure optimal~~ to remain in the community while ensuring his health ~~and~~, safety ~~while remaining in the community~~, and welfare.

"Preadmission screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening for [certain] long-term care services [requiring NF eligibility] ; (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~~ provide a list to individuals ~~to the~~ of appropriate ~~provider~~ providers 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~~ Team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Primary caregiver" means the ~~primary~~ person who consistently assumes the ~~rule~~ primary role of providing direct care and support of the waiver individual to live successfully in the community without receiving compensation for providing such care. Such person's name [, if applicable,] shall be documented by the RN or services facilitator in the waiver individual's record. [Waiver individuals are not required to have a primary caregiver in order to participate in the EDCD waiver.]

[~~"Prior authorization" or "PA" (also "service authorization" or "Srv Auth") means the process of approving either by DMAS, its prior authorization (or service authorization) contractor, or DMAS-designated entity for the purposes of reimbursement for the service for the individual before it is rendered or reimbursed.~~]

[~~"Prior (or service) authorization contractor" means DMAS or the entity that has been contracted by DMAS to perform prior, or service, authorization for medically necessary Medicaid covered home and community-based services.~~]

"Registered nurse" or "RN" means a person who is licensed or who holds multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice nursing.

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

"Respite services" means ~~those short-term personal care~~ services provided to waiver individuals who are unable to care for themselves that are furnished on a short-term basis because of the absence of or need for the relief of ~~those~~ the unpaid ~~caregivers~~ primary caregiver who normally ~~provide~~ provides the care.

"Service authorization" or "SRV AUTH" [~~(also "prior authorization")~~] means the process of approving either by DMAS, its service authorization [~~(or prior authorization)~~] contractor, or DMAS-designated entity, for the purposes of reimbursement for a service for the individual before it is rendered or reimbursed.

["Service authorization contractor" means DMAS or the entity that has been contracted by DMAS to perform service authorization for medically necessary Medicaid covered home and community-based services.]

"Services facilitation" means a service that assists the waiver individual (or family/caregiver, as appropriate) in arranging for, directing, training, and managing services provided through the consumer-directed model of service.

"Services facilitator" means a DMAS-enrolled provider or DMAS-designated entity

who is responsible for supporting the individual and the individual's family/caregiver or EOR, as appropriate, by ensuring the development and monitoring of the CD services plans of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services. Services facilitator shall be deemed to mean the same thing as consumer-directed services facilitator.

"State Plan for Medical Assistance" or "State Plan" means the ~~regulations~~ Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Skilled respite services" means temporary skilled nursing services that are provided to waiver individuals who need such services and that are performed by a LPN for the relief of the unpaid primary caregiver who normally provides the care.

"Transition coordinator" means the ~~DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver, as appropriate, with the activities associated with transitioning from an institution to the community. 12VAC30-120-2000 provides the service description, criteria, service units and limitations, and provider requirements for this service~~ person [~~as~~] defined [~~at~~ in] 12VAC30-120-2000 who facilitates MFP transition.

"Transition services" means set-up expenses for ~~individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service~~ individuals as defined at 12VAC30-120-2010.

~~"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that is completed by the Preadmission Screening Team that assesses an individual's physical health, mental health, and social and functional abilities to determine if the individual meets the nursing facility level of care.~~

["VDH" means the Virginia Department of Health.]

"VDSS" means the Virginia Department of Social Services.

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional comprehensive assessment that is completed by the Preadmission Screening Team or approved hospital discharge planner that assesses an individual's physical health, mental health, and psycho/social and functional abilities to determine if the individual meets the nursing facility level of care.

"Weekly" means a span of time covering seven consecutive calendar days.

12VAC30-120-905
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-905. Waiver description and legal authority.

A. The Elderly [~~and~~ or] Disabled with Consumer Direction (EDCD) Waiver operates under the authority of § 1915 (c) of the Social Security Act and 42 CFR 430.25(b) which permit the waiver of certain State Plan requirements. These federal statutory and regulatory provisions permit the establishment of Medicaid waivers to afford the states with greater flexibility to devise different approaches to the provision of long-term care (LTC) services. Under this § 1915(c) waiver, DMAS

waives § 1902(a)(10)(B) and (C) of the Social Security Act related to comparability of services.

B. This waiver provides Medicaid individuals who are elderly or who have a disability with supportive services to enable such individuals to remain in their communities thereby avoiding institutionalization.

C. Federal waiver requirements provide that the current aggregate average cost of care fiscal year expenditures under this waiver shall not exceed the average per capita expenditures in the aggregate for the level of care (LOC) provided in a nursing facility (NF) under the State Plan that would have been provided had the waiver not been granted.

D. DMAS shall be the single state agency authority pursuant to 42 CFR 431.10 responsible for the processing and payment of claims for the services covered in this waiver and for obtaining federal financial participation from CMS.

E. [~~EDCD services shall not be offered or provided to an individual who resides outside of the physical boundaries of the United States. With the exception of brief illnesses or vacations, coverage of waiver services may not be provided during brief absences from the Commonwealth and requires prior authorization (PA) by either DMAS or its designated prior service authorization contractor. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR) Individuals with Intellectual Disabilities (ICF/IID), inpatient rehabilitation facility, assisted living facility licensed by VDSS that serves five or more individuals, or a group home licensed by DBHDS~~. Payments for EDCD waiver services shall not be provided to any financial institution or entity located outside of the United States pursuant to the *Social Security Act* § 1902(a)(80). Payments for EDCD waiver services furnished in another state shall (1) be provided for an individual who meets the requirements of 42 CFR § 431.52, and (2) be limited to the same service limitations that exist when services are rendered within the Commonwealth's political boundaries. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), inpatient rehabilitation facility, assisted living facility licensed by VDSS that serves five or more individuals, or a group home licensed by DBHDS.]

F. An individual shall not be simultaneously enrolled in more than one waiver program but may be listed on the waiting list for another waiver program as long as criteria are met for both waiver programs.

G. DMAS shall be responsible for assuring appropriate placement of the individual in home and community-based waiver services and shall have the authority to terminate such services for the individual for the reasons set out below.

[~~H.~~1. ~~No waiver~~ Waiver] services shall [not] be reimbursed until [~~after both~~] the provider [~~enrollment process~~ is enrolled] and [the] individual eligibility process [~~have been completed~~ is complete] .

[~~I.~~2.] DMAS payment for services under this waiver shall be considered payment in full and no balance billing by the provider to the waiver individual, family/caregiver, employer of record (EOR), or any other family member of the waiver individual shall be permitted.

[3. Additional voluntary payments or gifts from family members shall not be accepted by providers of services.]

[~~J.~~4.] DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794). EDCD services

shall not be authorized if another entity is required to provide the services, (e.g. schools, insurance, [~~etc.~~]) because these waiver services shall not duplicate payment for services available through other programs or funding streams.

[~~K.~~H.] In the case of termination of home and community-based waiver services by DMAS, individuals shall be notified of their appeal rights pursuant to 12VAC30-110. DMAS, or the designated [~~PA~~ SRV Auth] contractor, shall have the responsibility and the authority to terminate the receipt of home and community-based care services by the waiver individual for any of the following reasons:

1. The home and community-based care services are no longer the critical alternative to prevent or delay institutional placement within 30 days;

2. The waiver individual is no longer eligible for Medicaid;

3. The waiver individual no longer meets the NF criteria;

4. The waiver individual's environment in the community does not provide for his health, safety, [~~and~~ or] welfare; [~~or~~]

5. [The waiver individual does not have a backup plan for services in the event the provider is unable to provide services, or]

[6.] Any other circumstances (including hospitalization) that cause services to cease or be interrupted for more than 30 consecutive [calendar] days. In such cases, such individuals shall be referred back to the local department of social services for redetermination of their [Medicaid] eligibility.

12VAC30-120-910
12VAC30-120-910. ~~General coverage and requirements for Elderly or Disabled with Consumer Direction Waiver services.~~ (Repealed.)

~~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 § 1614 of the Social Security Act; or~~

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

~~B. Covered services.~~

~~1. Covered services shall include: adult day health care, personal care (both consumer-directed and agency-directed), respite services (consumer-directed, agency-directed, and facility-based), PERS, assistive technology, environmental modifications, transition coordinator and transition services. Assistive technology and environmental modification services shall be available only to those EDCD waiver enrollees who are participants in the Money Follows the Person demonstration.~~

~~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, transition services, transition coordination, assistive technology, environmental modifications, 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. Assistive technology and environmental modification services shall be available only to those EDCD waiver enrollees who are participants in the Money Follows the~~

~~Person demonstration.~~

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

12VAC30-120-920
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-920. Individual eligibility requirements.

A. 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 (NF):

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

2. Individuals who have a disability as defined by § 1614 of the Social Security Act.

~~A.~~ B. 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~~ shall be considered as if they were institutionalized in a NF for the purpose of applying institutional deeming rules. All ~~recipients under~~ individuals in the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care (LOC) 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 waiver 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~~ shall reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For waiver 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 waiver individual that is equal to 165% of 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 waiver 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 waiver 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.~~ [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 waiver individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the waiver 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~~ a waiver individual with only a spouse at home, the community spousal income allowance is 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 is 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 waiver individuals to whom § 1924(d) of the Social Security Act does not apply, deduct the following in the respective order:

(1) An amount for the maintenance needs of the waiver individual that is equal to 165% of 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 waiver individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for waiver 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.~~ [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 that 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.~~ C. 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~~ NF, home and community-based waiver services shall be considered only for individuals who are eligible for admission [within 30 calendar days] to a ~~nursing facility~~ NF. 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~~ NF.

2. The individual's eligibility for home and community-based services shall be determined by the Preadmission Screening Team or DMAS-enrolled hospital provider after completion of a thorough assessment of the individual's needs and available support. If an individual meets ~~nursing facility~~ NF criteria and in the absence of community-based services, is at risk of NF placement within 30 days, the Preadmission Screening Team or DMAS-enrolled hospital provider shall provide the individual and family/caregiver with the choice of ~~Elderly or Disabled with Consumer Direction~~ EDCD Waiver services ~~or nursing facility~~, other appropriate services, NF placement, or Program of All Inclusive Care for the Elderly (PACE) enrollment [for people 55 years of age or older] , where available.

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

4. Medicaid ~~will~~ shall 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 or DMAS-enrolled hospital provider and the physician signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96).

5. Before Medicaid ~~will~~ shall assume payment responsibility of home and community-based services, ~~preauthorization~~ [~~prior authorization/service~~ service] authorization must be obtained from DMAS or the DMAS designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor ~~on~~, in accordance with DMAS policy, for all services requiring ~~preauthorization~~ [~~prior authorization/service~~ service] authorization. Providers ~~must~~ shall submit all required information to DMAS or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor within 10 business days of initiating care or within 10 business days of receiving verification of Medicaid eligibility from the local ~~DSS~~ department of social services. If the provider submits all required information to DMAS or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor within 10 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)~~ DMAS 96 form. If the provider does not submit all required information to DMAS or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor within 10 business days of initiating care, the services may be authorized beginning with the date all required information was received by DMAS or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor, but in no event preceding the date of the ~~Preadmission Screening Team~~ physician's signature on the DMAS-96 form.

6. Once ~~services for the individual have been authorized by the designated preauthorization contractor~~ waiver eligibility has been determined by the preadmission screening team or DMAS-enrolled hospital provider and referrals have been initiated, the [~~provider/services facilitator will~~ provider] shall submit a ~~Patient Information Form (DMAS-122),~~ Medicaid LTC Communication Form (DMAS-225) ~~along with a written confirmation of level of care eligibility from the designated preauthorization contractor,~~ to the local ~~DSS~~ department of social services to determine financial eligibility for the waiver program and any patient pay responsibilities. If the waiver individual who is receiving EDCD Waiver services has a patient pay amount, a provider shall use the electronic patient pay process for the required monthly monitoring of relevant changes. Local

departments of social services shall enter data regarding a waiver individual's patient pay amount obligation into the Medicaid Management Information System (MMIS) at the time action is taken on behalf of the individual either as a result of an application for LTC services, redetermination of eligibility, or reported change or changes in a waiver individual's situation. Procedures for the verification of a waiver individual's patient pay obligation are available in the appropriate Medicaid provider manual.

7. After the [~~provider/services facilitator~~ provider] has received ~~written~~ notification ~~of Medicaid eligibility~~ via the DMAS-225 process by ~~DSS~~ the local department of social services and ~~written~~ enrollment confirmation from DMAS or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor, the [~~provider/services facilitator~~ provider] shall inform the individual or family/caregiver so that services may be initiated.

~~7. The provider/services 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 form to all service providers when obtained.~~

8. The [~~provider/services facilitator~~ provider] shall be responsible for notifying the local department of social services via the DMAS-225 when there is an interruption of services for 30 consecutive calendar days or upon discharge from the [~~provider/services facilitator's~~ provider's] services.

~~8.~~ 9. Home and community-based care services shall not be offered or provided to any individual who resides in a ~~nursing facility~~ NF, an ~~intermediate care facility for the mentally retarded~~ [~~ICF/MR~~ ICF/IID] , a hospital, an assisted living facility licensed by ~~DSS~~ VDSS that serves five or more individuals, or a group home licensed by the [~~Department of] Mental Health, Mental Retardation and Substance Abuse Services~~ [~~Behavioral Health and Developmental Services~~ DBHDS.] [~~with the exception of transition~~ Transition] coordination and transition services [~~which shall~~ may] be [~~provided only~~ available] to individuals residing in [~~a NF or ICF/MR~~ some settings as approved by CMS through the Money Follows the Person demonstration program] . ~~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.~~

~~9.~~ 10. Certain home and community-based services shall not be available to individuals residing in an assisted living facility licensed by ~~DSS~~ VDSS that serves four or fewer individuals. These services are: respite, PERS, ADHC, environmental modifications and transition services. Personal care services ~~are~~ shall be covered for individuals living in these facilities but shall be limited to [~~ADL~~ personal] care not to exceed five hours per day ~~of ADL care~~. Personal care services shall be authorized based on the waiver individual's documented need for care over and above that provided by the facility.

11. Individuals who are receiving Auxiliary Grants shall not be eligible for EDCD enrollment or services.

~~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.~~

D. Waiver individual responsibilities under the consumer-directed (CD) model.

1. The individual [~~must~~ shall] be authorized for CD services and [the EOR shall] successfully complete consumer/ [employee] management training performed by the CD services facilitator before the waiver [~~individual~~ individual/EOR] shall be

permitted to hire a personal care attendant for Medicaid reimbursement. Any services rendered by an attendant prior to dates authorized by Medicaid shall not be eligible for reimbursement by Medicaid. Individuals who are eligible for CD services [~~must~~ shall] have the capability to hire and train their own personal care attendants and supervise the attendants' performance including, but not limited to, creating and maintaining complete and accurate timesheets. Individuals [~~with cognitive impairments who are unable to manage their own care~~] may have a [~~family/caregiver~~ family member, caregiver or another person] serve as the EOR on their behalf.

2. The [~~family/caregiver~~ person] that serves as the EOR on behalf of the waiver individual shall not be permitted to be the paid attendant for respite services [, or] personal care services [~~,~~] or the services facilitator.

3. Individuals will acknowledge that they will not knowingly continue to accept CD personal care services when the service is no longer appropriate or necessary for their care needs and shall inform the services facilitator. If CD services continue after services have been terminated by DMAS or the designated [~~PA~~ Srv Auth] contractor, the waiver individual shall be held liable for attendant compensation.

4. Individuals shall notify the CD services facilitator of all hospitalizations and admission to any rehabilitation facility, rehabilitation unit, or NF. Failure to do so may result in the waiver individual being liable for employee compensation.

12VAC30-120-924
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-924. Covered services; limits on covered services.

A. Covered services in the EDCD Waiver shall include: adult day health care, personal care (both consumer-directed and agency-directed), respite services (both consumer-directed and agency-directed), PERS, PERS medication monitoring, limited assistive technology, limited environmental modifications, transition coordination, and transition services.

1. The services covered in this waiver shall be appropriate and medically necessary to maintain the individual in the community in order to prevent institutionalization and shall be cost effective in the aggregate as compared to the alternative NF placement.

2. EDCD services shall not be authorized if another entity is required to provide the services (e.g., schools, insurance, [~~etc.~~]). Waiver services shall not duplicate services available through other programs or funding streams.

3. Assistive technology and environmental modification services shall be available only to those EDCD Waiver individuals who are also participants in the Money Follows the Person (MFP) (12VAC30-120-2000 [et seq.]) demonstration program.

4. An individual receiving EDCD Waiver services who is also getting hospice care may receive Medicaid-covered personal care (agency-directed and consumer-directed), respite care (agency-directed and consumer-directed), adult day health care, transition services, transition coordination, and PERS services, regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Such dual waiver/hospice individuals shall only be able to receive assistive technology and environmental modifications if they are also participants in the MFP demonstration program.

B. Voluntary/involuntary disenrollment from consumer-directed services. In either voluntary or involuntary disenrollment situations, the waiver individual shall be permitted to select an agency from which to receive his agency-directed personal

care and respite services.

1. A waiver individual may be found to be ineligible [~~, under certain circumstances,~~ for CD services] by either the Pre-admission Screening Team, DMAS-enrolled hospital provider, DMAS, its designated agent, or the CD services facilitator [~~,~~ .] [An individual may [not] ~~to~~ begin [~~to receive~~] or [~~to~~] continue to receive CD services if there are circumstances where the waiver individual's health, safety, or welfare cannot be assured, including but not limited to:

a. It is determined that the waiver individual cannot be the EOR and no one else is able to assume this role;

b. The waiver individual cannot [~~assure~~ ensure] his own health, safety, or welfare or develop an emergency back-up [~~POC~~ plan] that will [~~assure~~ ensure] his health, safety, or welfare; or

c. The waiver individual has medication or skilled nursing needs or medical or behavioral conditions that cannot be met through CD services [or other services] .

2. The waiver individual may be involuntarily disenrolled from consumer direction if he or the EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's timesheets.

3. In situations where either (i) the waiver individual's health, safety, or welfare cannot be assured or (ii) attendant timesheet discrepancies are known, the services facilitator shall assist as requested with the waiver individual's transfer to agency-directed services as follows:

a. Verify that essential training has been provided to the waiver individual or EOR;

b. Document, in the waiver individual's case record, the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator;

c. Discuss with the waiver individual or the EOR, as appropriate, the agency-directed option that is available and the actions needed to arrange for such services and offer choice of potential providers, and

d. Provide written notice to the waiver individual [~~and EOR, as appropriate,~~] of the right to appeal such involuntary termination of consumer direction. Such notice shall be given at least 10 [calendar] days prior to the effective date of this change. [In cases when the individual's or the provider personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.]

C. Adult day health care (ADHC) services. ADHC services shall only be offered to waiver individuals who meet pre-admission screening criteria as established in 12VAC30-60-300 [et seq.] and for whom ADHC services shall be an appropriate and medically necessary alternative to institutional care. ADHC services may be offered to individuals in a VDSS-licensed adult day care center (ADCC) congregate setting. ADHC may be offered either as the sole home and community-based care service or in conjunction with personal care (either agency-directed or consumer-directed), respite care (either agency-directed or consumer-directed), or PERS. A multi-disciplinary approach to developing, implementing, and evaluating each waiver individual's POC shall be essential to quality ADHC services.

1. ADHC services shall be designed to prevent institutionalization by providing waiver individuals with health care services, maintenance of their physical and mental conditions, and [coordination of] rehabilitation services [~~, as may be appropriate,~~] in a congregate daytime setting and shall be tailored to their unique

needs. The minimum range of services that shall be made available to every waiver individual shall be: assistance with ADLs, nursing services, coordination of rehabilitation services, [~~transportation,~~] nutrition, social services, recreation, and socialization services.

a. Assistance with ADLs shall include supervision of the waiver individual and assistance with management of the individual's POC.

b. Nursing services shall include the periodic evaluation, at least every 90 days, of the waiver individual's nursing needs; provision of indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervision of the waiver individual in self-administered medication; support of families in their home care efforts for the waiver individuals through education and counseling; and helping families identify and appropriately utilize health care resources. [Periodic evaluations may occur more frequently than every 90 days if indicated by the individual's changing condition.] Nursing services shall also include the general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications.

c. Coordination and implementation of rehabilitation services to ensure the waiver individual receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include physical therapy, occupational therapy, and speech therapy.

d. Nutrition services shall be provided to include, but not necessarily [be] limited to, one meal per day that meets the daily nutritional requirements pursuant to 22VAC40-60-800. Special diets and nutrition counseling shall be provided as required by the waiver individuals.

e. Recreation and social activities shall be provided that are suited to the needs of the waiver individuals and shall be designed to encourage physical exercise, prevent physical and mental deterioration, and stimulate social interaction.

f. ADHC coordination shall involve implementing the waiver individuals' POCs, updating such plans, recording 30-day progress notes, and reviewing the waiver individuals' daily logs each week.

2. Limits on covered ADHC services.

a. A day of ADHC services shall be defined as a minimum of six hours.

b. [~~Centers~~ ADCC] that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing; or (iv) any other procedures that require sterile technique. The ADCC shall not permit its aide employees to perform [~~such~~ skilled nursing] procedures.

c. At any time that the center is no longer able to provide reliable, continuous care to any of the center's waiver individuals for the number of hours per day or days per week as contained in the individuals' POCs, then the center shall contact the waiver individuals or [~~family/caregivers/EORs~~ family/caregivers] , as appropriate, to initiate other care arrangements for these individuals. The center may either subcontract with another ADCC or may transfer the waiver individual to another ADCC. The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge, at least 10 calendar days prior to the effective date of the discharge. In cases when the individual's or the center personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.

d. ADHC services shall not be provided, for the purpose of Medicaid

reimbursement, to individuals who reside in NFs, [~~ICFs/MR~~ ICFs/ID] , hospitals, assisted living facilities that are licensed by VDSS, or group homes that are licensed by DBHDS.

D. Agency-directed personal care services. Agency-directed personal care services shall only be offered to persons who meet the pre-admission screening criteria at 12VAC30-60-300 [et seq.] and for whom it shall be an appropriate alternative to institutional care. Agency-directed personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include, but shall not necessarily be limited to, assistance with ADLs, access to the community, [~~monitoring of self-administered~~ assistance with] medications [in accordance with VDH licensing requirements] or other medical needs, supervision, and the monitoring of health status and physical condition. Where the individual requires assistance with ADLs, and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20. Agency-directed personal care services may be provided in a home or 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-directed or consumer-directed), or PERS. [The provider shall document, in the individual's medical record, the waiver individual's choice of the agency-directed model.]

1. Criteria. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-300 [et seq. ~~that shall be~~ as] documented on the UAI assessment form [, and for whom it shall be an appropriate alternative to institutional care] .

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be needed if the waiver individual were receiving personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

c. The individual or family/caregiver shall have a back-up plan for the provision of services in the event the agency is unable to provide an aide.

2. Limits on covered agency-directed personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. DMAS shall reimburse for services delivered, consistent with the approved POC, for personal care that the personal care aide provides to the waiver individual to assist him while he is at work or postsecondary school.

[~~(1) Agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.~~]

([~~2~~ 1]) DMAS or the designated [~~PA/Srv Auth~~ Srv Auth] contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that are provided to him in the workplace or postsecondary school or both.

([3 2]) DMAS shall not pay for the personal care aide to assist the enrolled waiver individual with any functions or tasks related to the individual completing his job or postsecondary school functions or for supervision time during either work or postsecondary school or both.

c. Supervision services shall only be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no one else in the home competent and able to call for help in case of an emergency.

d. There shall be a [maximum] limit of eight hours per 24-hour day for supervision services [. Supervision services shall be documented ~~included~~] in the POC [as needed by the individual] .

[e. Agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.]

E. Agency-directed respite services. Agency-directed respite care services shall only be offered to waiver individuals who meet the pre-admission screening criteria at 12VAC30-60-300 [et seq.] and for whom it shall be an appropriate alternative to institutional care. Agency-directed respite care services may be either skilled nursing or unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include, but shall not be limited to, assistance with ADLs, access to the community, [~~monitoring of self-administration of~~ assistance with] medications [in accordance with VDH licensing requirements] or other medical needs, supervision, and monitoring health status and physical condition.

1. Respite care shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. Respite care services may be provided in the individual's home or other community settings.

2. When the individual requires assistance with ADLs, and where such assistance is specified in the waiver individual's POC, such supportive services may also include assistance with IADLs.

3. The unskilled care portion of this service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20.

4. Limits on service.

a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per individual per [~~calendar~~ state fiscal] year, to be [~~prior~~ service] authorized. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment for individuals who change waiver programs. Additionally, individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per [~~calendar~~ state fiscal] year combined.

b. If agency-directed respite service is the only service received by the waiver individual, it must be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the provider agency shall notify the local department of social services for its redetermination of eligibility for the waiver individual.

c. The individual or family/caregiver shall have a backup plan for the provision of services in the event the agency is unable to provide an aide.

F. Services facilitation for consumer-directed services. Consumer-directed personal care and respite care services shall only be offered to persons who meet the pre-admission screening criteria at 12VAC30-60-300 [et seq.] and for whom there shall be appropriate alternatives to institutional care.

1. Individuals who choose CD services shall receive support from a DMAS-enrolled CD services facilitator as required in conjunction with CD services. The services facilitator shall document the waiver individual's choice of the CD model and whether there is a need for [~~a family/caregiver~~ another person] to serve as the EOR on behalf of the individual. The CD services facilitator shall be responsible for assessing the waiver individual's particular needs for a requested CD service, assisting in the development of the POC, providing training to the [~~waiver individual and family/caregiver/EOR on their~~ EOR on his] responsibilities as an employer, and for providing ongoing support of the CD services.

2. Individuals who are eligible for CD services shall have, or have [~~a family/caregiver~~ an EOR] who has, the capability to hire and train the personal care attendant or attendants and supervise the attendant's performance, including approving the attendant's timesheets.

a. If a waiver individual is unwilling or unable to direct his own care or is younger than 18 years of age, a family/caregiver/designated person shall serve as the EOR on behalf of the waiver individual in order to perform these supervisory and approval functions.

b. Specific employer duties shall include checking references of personal care attendants [~~,~~ and] determining that personal care attendants meet [~~basic~~] qualifications [~~, and maintaining copies of attendants' timesheets to have available for review, on a consistent and timely basis, by the CD services facilitator, the fiscal employer/agent, DMAS, or DMAS' contracted entity~~] .

3. The individual or family/caregiver shall have a backup plan for the provision of services in case the attendant does not show up for work as scheduled or terminates employment without prior notice.

4. The CD services facilitator shall not be the waiver individual, [a CD attendant,] a provider of other Medicaid-covered services, spouse of the individual, parent of the individual who is a minor child, or the [~~family/caregiver/EOR~~ EOR] who is employing the CD attendant.

5. DMAS shall either provide for fiscal employer/agent services or contract for the services of a fiscal employer/agent for CD services. The fiscal employer/agent shall be reimbursed by DMAS or DMAS contractor (if the fiscal/employer agent service is contracted) to perform certain tasks as an agent for [~~either~~] the [~~waiver individual who is receiving CD services or the~~] EOR. The fiscal employer/agent shall handle responsibilities for the waiver individual including, but not limited to, employment taxes and background checks for attendants [~~, etc~~] . The fiscal employer/agent shall seek and obtain all necessary authorizations and approvals of the Internal Revenue Service in order to fulfill all of these duties.

G. Consumer-directed personal care services. CD personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include assistance with ADLs and may include, but shall not be limited to, access to the community, monitoring of self-administered medications or other medical needs, supervision, and monitoring health status and physical condition. Where the waiver individual requires assistance with ADLs and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g. catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC 90-20 and as permitted by [~~Chapter 790 of the 2010 Acts of Assembly~~ the *Code of Virginia* §54.1-3000 et

seq] . CD personal care services may be provided in a home or 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 service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS.

1. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-300 [et seq. ~~that shall be~~ as] documented on the UAI assessment instrument [, and for whom it shall be an appropriate alternative to institutional care] .

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the waiver individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be otherwise authorized had the individual chosen to receive personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

2. Limits on covered CD personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. There shall be a limit of eight hours per 24-hour day for supervision services included in the POC. Supervision services shall be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no one else in the home who is competent and able to call for help in case of an emergency.

c. Consumer-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.

3. CD personal care services at work or school shall be limited as follows:

a. DMAS shall reimburse for services delivered, consistent with the approved POC, for CD personal care that the attendant provides to the waiver individual to assist him while he is at work or postsecondary school or both.

b. DMAS or the designated [~~PA/Srv Auth~~ Srv Auth] contractor shall review the waiver 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 postsecondary school or both.

c. DMAS shall not pay for the personal care attendant to assist the waiver individual with any functions or tasks related to the individual completing his job or postsecondary school functions or for supervision time during work or postsecondary school or both.

H. Consumer-directed respite services. CD respite care services are unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include, but shall not be limited to, assistance with ADLs, access to the community, monitoring of self-administration of medications or other medical needs, supervision, monitoring health status and physical condition, and personal care services in a work environment.

1. In order to qualify for this service, the waiver individual shall have met the NF LOC criteria as set out in 12VAC30-60-300 [et seq. ~~that shall be~~ as] documented

on the UAI assessment instrument [, and for whom it shall be an appropriate alternative to institutional care] .

2. CD respite services shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. This service shall be provided in the waiver individual's home or other community settings.

3. When the waiver individual requires assistance with ADLs, and where such assistance is specified in the individual's POC, such supportive services may also include assistance with IADLs.

4. Limits on covered CD respite care services.

a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per waiver individual per [~~calendar~~ state fiscal] year. If a waiver individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per [~~calendar~~ state fiscal] year combined.

b. CD respite care services shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC90-20 and as permitted by [~~Chapter 790 of the 2010 Acts of Assembly~~ the *Code of Virginia* §54.1-3000 et seq].

c. If consumer-directed respite service is the only service received by the waiver individual, it shall be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the services facilitator shall refer the waiver individual to the local department of social services for its redetermination of eligibility for the waiver individual.

l. Personal emergency response system (PERS).

1. Service description. PERS is a service that monitors waiver 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 or system. PERS may also include medication monitoring devices.

a. PERS may be authorized only when there is no one else in the home with the waiver individual who is competent or continuously available to call for help in an emergency or when the individual is in imminent danger.

b. The use of PERS equipment shall not relieve the backup caregiver of his responsibilities.

c. Service units and service limitations.

(1) PERS shall be limited to waiver individuals who are ages 14 years and older who also either live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time [~~and who may otherwise require extensive routine supervision~~] . PERS shall only be provided in conjunction with receipt of personal care services (either agency-directed or consumer-directed), respite services (either agency-directed or consumer-directed), or adult day health care. A waiver individual shall not receive PERS if he has a cognitive impairment as defined in 12VAC 30-120-900.

(2) A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the

PERS. A unit of service shall be the one-month rental price set by DMAS in its fee schedule. The one-time installation of the unit shall include installation, account activation, individual and family/caregiver instruction, and subsequent removal of PERS equipment when it is no longer needed.

(3) PERS services shall be capable of being activated by a remote wireless device and shall be connected to the waiver individual's telephone line or system. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be (i) waterproof, (ii) able to automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, (iii) able to be worn by the waiver individual; and (iv) automatically reset by the response center after each activation, thereby ensuring that subsequent signals can be transmitted without requiring manual resetting by the waiver individual.

(4) All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard.

(5) Medication monitoring units shall be physician ordered. In order to be approved to receive the medication monitoring service, a waiver individual shall also receive PERS services. Physician orders shall be maintained in the waiver individual's record. In cases where the medical monitoring unit must be filled by the provider, the person who is filling the unit shall be either an RN or an LPN. The units may be filled as frequently as a minimum of every 14 days. There must be documentation of this action in the waiver individual's record.

J. Transition coordination and transition services. Transition coordination and transition services, as defined at 12VAC30-120-2000 and 12VAC30-120-2010, provide for applicants to move from institutional placements or licensed or certified provider-operated living arrangements to private homes or other qualified settings. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall coordinate with the transition coordinator to ensure that EDCD waiver eligibility criteria shall be met.

a. Transition coordination and transition services shall be authorized by DMAS or its designated agent in order for reimbursement to occur.

b. For the purposes of transition services, an institution [~~means an ICF/MR, as defined at 42 CFR 435.1010, a long-stay hospital, or NF~~ must meet the requirements as specified by CMS in the Money Follows the Person demonstration program [at **http://www.ssa.gov/OP_Home/comp2/F109-171.html#ft262**] .

c. Transition coordination shall be authorized for a maximum of 12 consecutive months upon discharge from an institutional placement and shall be initiated within 30 days of discharge from the institution.

d. Transition coordination and transition services shall be provided in conjunction with personal care (agency-directed or consumer-directed), respite (agency-directed or consumer-directed), or adult day health care services.

~~[EDITOR'S NOTE: 12VAC30-120-925 K 3 b and 12VAC30-120-925 L 3 b: When DMAS drafted these provisions in the proposed regulations, they were based upon a budget reduction legislative proposal to reduce the coverage of assistive technology (AT) and environmental modification (EM) services to $3,000. Subsequent to the submission of the draft proposed regulations for Executive review, the 2011 General Assembly funded both AT and EM services up to $5,000. DMAS has no present authority to change the proposed regulatory language as approved by the Governor; however, DMAS intends to correct these limits in the next final stage regulations to appropriately reflect the limit for AT and~~

~~EM services to the funded $5,000 level as approved by the 2011 General Assembly.~~]

K. Assistive Technology (AT).

1. Service description. Assistive technology (AT), as defined [~~herein~~ in 12 VAC 30-120-900] , shall only be available to waiver individuals who are participating in the MFP program pursuant to 12VAC 30-120-2000 [et seq.] .

2. In order to qualify for these services, the individual shall have a demonstrated need for equipment for remedial or direct medical benefit primarily in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. AT shall be covered in the least expensive, most cost-effective manner.

3. Service units and service limitations.

a. [~~AT shall be available to individuals receiving transition coordination through the MFP program.~~] All requests for AT shall be made by the transition coordinator to DMAS or the [~~PA/Srv Auth~~ Srv Auth] contractor.

b. [~~Effective July 1, 2011, the~~ The] maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be [~~$3,000~~ $5,000] per [~~calendar~~] year for individuals regardless of waiver, or regardless of whether the individual changes waiver programs, for which AT is approved. [~~Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of CY 2011 (subject to the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of CY 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period.~~] The service unit shall always be one, for the total cost of all AT being requested for a specific timeframe.

c. AT may be provided in the individual's home or community setting.

[~~d. A maximum expenditure limit shall be consistent with 12VAC30-120-762 during the MFP enrollment period (maximum of 12 months).~~] .

[~~e~~ d] . AT shall not be approved for purposes of convenience of the caregiver/provider or restraint of the individual.

[f e] . An independent, professional consultation shall be obtained from [a] qualified [~~professionals~~ professional] who [~~are~~ is] knowledgeable of that item for each AT request prior to approval by the [~~PA/Srv Auth~~ Srv Auth] agent and may include training on such AT by the qualified professional. [The consultation shall not be performed by the provider of AT to the individual.]

[~~g~~ f] . All AT shall be prior authorized by the [~~PA/Srv Auth agent~~ Srv Auth contractor] prior to billing.

[~~h~~ g] . Excluded shall be items that are reasonable accommodation requirements [, for example,] of the Americans with Disabilities Act, the Virginians with Disabilities Act, or the Rehabilitation Act or that are required to be provided through other funding sources [~~(insurance, schools, etc.)~~] .

[~~i~~ h] . AT services or equipment shall not be rented but shall be purchased.

L. Environmental Modifications (EM).

1. Service description. Environmental modifications (EM), as defined herein, shall only be available to waiver individuals who are participating in the MFP program pursuant to 12VAC30-120-2000 [et seq.] . Adaptations shall be documented in the waiver individual's POC and may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the waiver individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, flooring, roof repairs, central air conditioning, [ete or decks] . Adaptations that add to the total square footage of the home shall be excluded from this benefit, except when necessary to complete an [authorized] adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications must be prior authorized by the [PA/Srv Auth agent Srv Auth contractor] . Modifications may only be made to a vehicle if it is the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles.

2. In order to qualify for these services, the waiver individual [must shall] have a demonstrated need for modifications of a remedial or medical benefit offered in [an individual's his] primary home or primary vehicle used by the waiver individual to [ensure his health, welfare, or safety or] specifically [to] improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. EM shall be covered in the least expensive, most cost-effective manner.

3. Service units and service limitations. [EM shall be available to individuals who are receiving transition coordination.]

a. All requests for EM shall be made by the MFP transition coordinator to DMAS or the [PA/Srv Srv] Auth contractor.

b. [Effective July 1, 2011, the The] maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be [$3,000 $5,000] per [calendar] year for individuals regardless of waiver, or regardless of whether the individual changes waiver programs, for which EM is approved. [Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of CY 2011 (subject to the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of CY 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period.] The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

[c. To receive environmental modifications in the EDCD waiver, the individual shall be receiving at least one other waiver service.]

[d . A maximum expenditure limit for EM services shall be consistent with 12VAC30-120-758 per the 12 month MFP enrollment period (12 months maximum).]

[e c] . All EM shall be [prior] authorized by the [PA/Srv Auth Srv Auth] agent prior to billing.

[f d] . Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act,

the Virginians with Disabilities Act, and the Rehabilitation Act.

[~~g~~ e] . Transition coordinators shall, upon completion of each modification, meet face-to-face with the waiver individual and his family/caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual.

[~~h~~ f] . EM shall not be approved for purposes of convenience of the caregiver/provider or restraint of the waiver individual.

12VAC30-120-925
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-925. Respite coverage in children's residential facilities.

A. Individuals with special needs who are enrolled in the EDCD waiver and who have a diagnosis of intellectual disability (ID) shall be eligible to receive respite services in children's residential facilities that are licensed for respite services for children with ID.

B. These respite services shall be covered consistent with the requirements of [~~12VAC30-120-925 or 12VAC30-120-960~~ 12 VAC 30-120-924, 12 VAC 30-120-930, and 12 VAC 30-120-935] , whichever is in effect at the time of service delivery.

12VAC30-120-930
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

A. Requests for participation ~~will~~ shall be screened by DMAS or the designated DMAS contractor to determine whether the [~~provider/services facilitator~~ provider] applicant meets ~~these basic~~ the requirements for participation, as set out in the provider agreement, and demonstrates the abilities to perform, at a minimum, the following activities:

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal healthcare programs, including Medicaid (i.e., via the United States Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219, or email to providerexclusions@dmas.virginia.gov.

~~1.~~ 2. Immediately notify DMAS in writing of any change in the information that the provider previously submitted to DMAS;

~~2. Assure~~ 3. Except for waiver individuals who are subject to the DMAS Client Medical Management program Part VIII (12VAC30-130-800 et seq.) of 12VAC 30-130 or are enrolled in a Medicaid managed care program, [ensure] 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.~~ 4. [~~Assure~~ Ensure] the individual's freedom to refuse medical care, treatment, and services;

~~4.~~ 5. Accept referrals for services only when staff is available to initiate and

perform such services on an ongoing basis;

~~5.~~ 6. Provide services and supplies to individuals in full compliance with Title VI (42 USC § 2000d et seq.) of the Civil Rights Act of 1964 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 (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990 (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.~~ 7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as ~~is~~ are provided to the general public;

~~7.~~ 8. 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.~~ 9. Use only DMAS-designated forms for service documentation. The provider ~~must~~ shall not alter the DMAS forms in any manner ~~unless~~ without prior written approval from DMAS ~~is obtained prior to using the altered forms~~;

~~9.~~ 10. Use DMAS-designated billing forms for submission of charges;

~~10. Not perform any~~ 11. Perform no type of direct marketing activities to Medicaid individuals;

~~11.~~ 12. 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 a period of at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for a period of at least six years after such minor has reached 18 years of age.

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.~~ 13. Furnish information on the request of and in the form requested to DMAS, the Attorney General of Virginia or ~~his~~ their 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.~~ 14. 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, 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. Pursuant to 42 CFR 431.300 et seq., § 32.1-325.3 of the Code of Virginia, and the Health Insurance Portability and Accountability Act (HIPAA), [safeguard and hold confidential] all information associated with an applicant or enrollee or individual that could disclose the applicant's/enrollee's/individual's identity [~~is confidential and shall be safeguarded~~] . Access to information concerning the applicant/enrollee/individual shall be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency and any such access must be in accordance with the provisions found in 12VAC30-20-90;

~~15.~~ 16. When ownership of the provider changes, notify DMAS in writing at least 15 calendar days before the date of change;

~~16.~~ 17. Pursuant to §§ 63.2-1509 [~~and~~,] 63.2-1606 [, and 63.2-100] of the Code of Virginia, if a participating provider or the provider's staff 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~~ shall report this immediately from first knowledge or suspicion of such knowledge to the local ~~DSS~~ department of social services adult or child protective services worker as applicable or to the toll-free, 24-hour hotline as described on the local department of social services' website. Employers shall ensure and document that their staff is aware of this requirement;

~~17.~~ 18. In addition to compliance with the general conditions and requirements, adhere to the conditions of participation outlined in the individual provider's participation agreements ~~and~~, in the applicable DMAS provider manual, and in other DMAS laws, regulations, and policies. DMAS shall conduct ongoing monitoring of compliance with ~~provider's~~ 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; ~~and~~

~~18.~~ 19. Meet 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 Code of Virginia regarding criminal record checks.~~

a. For reasons of Medicaid individuals' safety and welfare, all employees shall have a satisfactory work record, as evidenced by at least two references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children [~~(including a founded adult protective services complaint)~~]. In instances of employees who have worked for only one employer, such employees shall be permitted to provide one employment reference and one personal reference. [In instances when prospective employers are unable to secure two prior job references and verification of employment history, they shall document their good faith efforts to do so in the new employees' records and shall provide such documentation to either DMAS or its audit contractor upon request.]

b. [~~The criminal~~ Criminal] record [~~and sex offender registry check results~~ checks] for both employees and volunteers [~~as~~] conducted by the Virginia State Police [. Proof that these checks were performed with satisfactory results] shall be available for review by DMAS staff or its designated agent who are authorized

by the agency to review these files. DMAS shall not reimburse the provider for any services provided by an employee or volunteer who has been convicted of committing a barrier crime as defined in § 32.1-162.9:1 [~~or 63.2-1719~~] of the Code of Virginia. Providers shall be responsible for complying with §§ 32.1-162.9:1 [~~and 63.2-1719~~] of the Code of Virginia regarding criminal record checks. Provider staff shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the criminal record check [~~or sex offender register check~~] confirms the provider's staff person or volunteer was convicted of a barrier crime [~~or is listed in any sex offender registry~~] .

c. Provider staff and volunteers that serve waiver individuals who are minor children shall also be screened through the VDSS Child Protective Services (CPS) Central Registry. Provider staff and volunteers shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the VDSS CPS Central Registry check confirms the provider's staff person or volunteer has a finding.

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.~~ DMAS shall terminate the [~~provider's/services facilitator's~~ provider's] Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories shall within 30 days of such conviction notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations, subject to applicable appeal rights, shall conform to § 32.1-325 D and E of the Code of Virginia and Part VII (12VAC30-20-500 et seq.) of 12VAC30-20.

C. For DMAS to approve [~~provider's/services facilitator's~~ provider] agreements with home and community-based waiver providers, the following standards shall be met:

1. Staffing, financial solvency, disclosure of ownership, and [~~assurance of~~ ensuring] comparability of services requirements as specified in the applicable provider manual;

2. The ability to document and maintain waiver individuals' case records in accordance with state and federal requirements;

3. Compliance with all applicable laws, regulations, and policies pertaining to EDCD Waiver services.

~~C.~~ D. The waiver individual shall have the option of selecting the provider of his choice from among those [~~providers/services facilitators~~ providers] who are approved and who can appropriately meet his needs.

~~D.~~ E. A participating [~~provider/services facilitator~~ provider] may voluntarily terminate his participation in Medicaid by providing 30 days' written notification to DMAS.

~~E.~~ F. DMAS may terminate at-will a [~~provider's/services facilitator's~~ provider's] participation agreement on 30 days' written notice as specified in the DMAS participation agreement. DMAS may immediately terminate a [~~provider's/services facilitator's~~ provider's] participation agreement if the [~~provider/services facilitator~~ 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 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.~~

~~G. The Medicaid provider agreement shall terminate upon conviction of the provider of a felony pursuant to § 32.1-325 of the Code of Virginia. 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.~~ G. The [~~provider/services facilitator~~ provider] ~~is~~ shall be responsible for ~~the Patient Information Form (DMAS-122)~~ completing the DMAS-225 form. The ~~service~~ [~~provider/services facilitator's provider~~ provider] shall notify the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor, as appropriate, and the local ~~DSS, and DMAS,~~ department of social services, in writing, when any of the following ~~circumstances~~ events occur. Furthermore, it shall be the responsibility of the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor to also update DMAS, as requested, when any of the following events occur:

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

2. ~~An~~ A waiver individual dies;

3. ~~An~~ A waiver individual is discharged from [the provider's] EDCD waiver services;

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

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

~~I.~~ H. Changes or termination of services.

1. The [~~provider/services facilitator~~ provider] may decrease the amount of authorized care if the revised ~~plan of care~~ POC is appropriate and based on the medical needs of the waiver individual. ~~If the individual disagrees with the proposed decrease, the individual has the right to appeal to DMAS.~~ The participating [~~provider/services facilitator~~ provider] ~~is responsible for developing the new plan of care and calculating the new hours of service delivery~~ shall collaborate with the waiver individual or the family/caregiver/EOR, or both as appropriate, to develop the new POC and calculate the new hours of service delivery. The ~~individual or person responsible for supervising the individual's care~~ [~~provider/services facilitator~~ provider] shall discuss the decrease in care with the waiver individual or family/caregiver/EOR, document the conversation in the waiver individual's record, and notify the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor. The ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor ~~will notify~~ shall process the decrease request and the waiver individual [~~or family~~ family/caregiver/EOR] shall be notified of the change by letter. This letter shall clearly state the waiver individual's right to appeal this change.

2. If a change in the waiver individual's condition necessitates an increase in care, the participating [~~provider/services facilitator~~ provider] ~~must~~ shall assess the need for the increase and, [~~if appropriate,~~] collaborate with the waiver individual and [~~family/caregiver~~ family/caregiver/EOR] , as appropriate, to develop a ~~plan of care~~ POC for services to meet the changed needs. The [~~provider/services facilitator~~ provider] may implement the increase in personal/respite care hours without approval from DMAS, or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv

Auth] contractor, if the amount of services does not exceed the total 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.

3. Any increase to [~~an~~ a] waiver individual's ~~plan of care~~ POC that exceeds the number of hours allowed for that individual's level of care or any change in the waiver individual's level of care ~~must~~ shall be ~~preauthorized~~ authorized by DMAS or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor prior to the increase and be accompanied by adequate documentation justifying the increase.

~~3.~~ 4. In an emergency situation when either the health ~~and~~, safety, or welfare of the waiver individual or provider personnel is endangered, or both, DMAS, or the designated ~~preauthorization~~ [~~PA/Srv Auth~~ Srv Auth] contractor, ~~must~~ shall be notified prior to discontinuing services. The written notification period set out below shall not be required. If appropriate, ~~the~~ local ~~DSS~~ department of social services adult or child protective services ~~department must~~, as may be appropriate, shall be notified immediately. Appeal rights shall be afforded to the waiver individual.

~~4.~~ 5. In a nonemergency situation, ~~i.e.,~~ when neither the health ~~and~~, safety, nor welfare of the waiver individual or [~~provider/services facilitator~~ provider] personnel is ~~not~~ endangered, the participating provider~~, other than a PERS provider~~, shall give the waiver individual [~~or family/caregiver, or both,~~] at least 10 calendar days' written notification (plus three days ~~for mailing~~ [~~(~~] for mail transit [~~)~~] for a total of 13 calendar days from the letter's date) of the intent to discontinue services. The notification letter shall provide the reasons for and the effective date the provider ~~is~~ will be 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.~~ Appeal rights shall be afforded to the waiver individual.

~~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. 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.~~

I. Staff education and training requirements.

1. RNs shall [: (i)] be currently licensed to practice in the Commonwealth as an RN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia [~~, and~~ ; (ii)] have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or NF, or as an LPN who worked for at least one year in one of these settings [~~,~~ and; (iii) submit to a criminal records check and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The

RN shall not be compensated for services provided to the waiver individual if this record check verifies that the RN has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the RN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.]

2. LPNs shall work under supervision as set out in 18VAC90-20-270. LPNs shall [: (i)] be currently licensed to practice in the Commonwealth as an LPN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia [~~, and~~ ; (ii)] shall have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or NF. The LPN shall meet the qualifications and skills, prior to being assigned to care for the waiver individual, that are required by the individual's POC [; and; (iii) submit to a criminal records check and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The LPN shall not be compensated for services provided to the waiver individual if this record check verifies that the LPN has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the LPN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.]

3. Personal care aides who are employed by personal care agencies that are licensed by the Virginia Department of Health (VDH) shall meet the requirements [~~resulting from Chapter 790 of the 2010 Acts of Assembly~~ of 12 VAC 5-381-10 et seq.] . In addition, personal care aides shall also [~~be required to physically attend~~ receive] annually a minimum of 12 [documented] hours of agency-provided training in the performance of these services. [~~On-line computer classes shall not satisfy this training requirement. ~~]

4. Personal care aides who are employed by personal care agencies that are not licensed by the VDH shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities, as ensured by the provider prior to being assigned to the care of an individual, and shall have the required skills and training to perform the services as specified in the waiver individual's POC and related supporting documentation.

a. Personal care aides' required initial (that is, at the onset of employment) training, as further detailed in the applicable provider manual, shall be met in one of the following ways: (i) registration with the Board of Nursing as a certified nurse aide; (ii) graduation from an approved educational curriculum as listed by the Board of Nursing; or (iii) completion of the provider's educational curriculum, that must be a minimum of 40 hours in duration, as taught by an RN who meets the same requirements as the RN listed in subdivision 1 of this subsection.

b. In addition, personal care aides shall also be required to [~~physically attend~~ receive] annually a minimum of 12 [documented] hours of agency-provided training in the performance of these services. [~~On-line computer classes shall not satisfy this training requirement. ~~]

[~~e.~~5] Personal care aides shall:

([~~1.~~a]) Be at least 18 years of age or older;

([~~2.~~b]) Be able to read and write English to the degree necessary to perform the expected tasks and create and maintain the required documentation;

([~~3.~~ c]) Be physically able to perform the required tasks and have the required skills to perform services as specified in the waiver individual's supporting documentation;

([~~4.~~d]) Have a valid social security number that has been issued to the personal care aide by the Social Security Administration;

([~~5~~ e]) Submit to a criminal records check and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. The aide shall not be compensated for services provided to the waiver individual [~~if this~~ effective the date in which the] record check verifies that the aide has been convicted of barrier crimes described in § 32.1-162.9:1 [~~or 63.2-1719~~] of the Code of Virginia or if the aide has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;

[~~(6) Submit to a check of records by a local department of social services to determine if he has been found to have abused, neglected, or exploited an adult 60 years of age or older or an adult who is 18 years of age or older and who is also incapacitated. The aide shall not be compensated for services provided to the waiver individual beginning with the date that such records are located; ~~]

([~~7~~ f]) Understand and agree to comply with the DMAS EDCD Waiver requirements; and

([~~8~~ g]) Receive tuberculosis (TB) screening as specified in the criteria used by the VDH.

[~~5~~ 6] . Consumer-directed personal care attendants shall:

a. Be 18 years of age or older;

[b. Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required documentation;] .

[~~b~~.c.] Be physically able to perform the [~~work~~ required tasks] and have the required skills to perform consumer-directed services as specified in the waiver individual's supporting documentation;

[~~c. Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required documentation; ~~]

d. Have a valid social security number that has been issued to the personal care attendant by the Social Security Administration;

e. Submit to a criminal records check and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. The attendant shall not be compensated for services provided to the waiver individual, [~~after the individual has been notified, if this~~ effective the date in which the] record check verifies that the attendant has been convicted of barrier crimes described in § 32.1-162.9:1 [~~or 63.2-1719~~] of the Code of Virginia or if the attendant has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;

[~~f. Submit to a check of records by a local department of social services to determine if he has been found to have abused, neglected, or exploited an adult 60 year of age or older or an adult who is 18 years of age or older and who is also incapacitated. The attendant shall not be compensated for services provided to the waiver individual beginning with the date that such records are located; ~~]

[~~g. Be willing to attend training at the individual's or family/caregiver's request; ~~]

[~~h~~ f] . Understand and agree to comply with the DMAS EDCD Waiver requirements; [~~and~~] .

[~~i~~g] . Receive tuberculosis (TB) screening as specified in the criteria used by the VDH [~~, and~~]

[h. Be willing to attend training at the individual's or family/caregiver's request [~~; and~~]

12VAC30-120-935
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-935. Participation standards for specific covered services.

A. The personal care, respite, [~~and~~] ADHC providers [and services facilitators] shall develop an individualized POC that addresses the waiver individual's service needs. Such plan [~~must~~ shall] be developed in collaboration with the waiver individual or the individual's family/caregiver/EOR, as appropriate.

B. Agency providers shall employ appropriately licensed professional staff [~~to~~ who can] provide the covered waiver services [~~as may be~~] required by the waiver individuals. [~~RNs/LPNs shall either be licensed as nursing professionals by the Commonwealth of Virginia or they shall hold multi-state licensing privilege pursuant to Chapter 30 (§ 54.1-3000 et. seq.) of Title 54.1 of the Code of Virginia.~~] Providers shall require that the supervising RN/LPN be available by phone at all times that the LPN/attendant [and consumer-directed services facilitators] , as appropriate, is providing services to the waiver individual.

C. Agency staff (RN, LPNs, or aides) or CD employees (attendants) shall not be reimbursed by DMAS for services rendered to waiver individuals when the agency staff or the CD employee is either (i) the spouse; or (ii) parent (biological, adoptive, legal guardian) or other legal guardian of the minor child waiver individual [~~or an adult waiver individual~~] .

D. Failure to meet the documentation standards as stated herein may result in DMAS charging audited providers with overpayments and requiring the return of the overpaid funds.

E. In addition to meeting the general conditions and requirements, home and community-based services participating providers shall also meet the following requirements:

1. ADHC services provider. In order to provide these services, the ADCC shall:

a. Make available a copy of the current VDSS license for DMAS' review and verification purposes prior to the provider applicant's enrollment as a Medicaid provider.

b. Adhere to VDSS' ADCC standards as defined in 22VAC40-60 including, but not limited to, provision of activities for waiver individuals; and

c. Employ the following:

(1) A director who shall be responsible for overall management of the center's programs and employees pursuant to 22VAC40-60-320. The director shall be the provider contact person for DMAS and the designated [~~PA/Srv Auth~~ Srv Auth] contractor and shall be responsible for responding to communication from DMAS and the designated [~~PA/Srv Auth~~ Srv Auth] contractor. The director shall be responsible for [~~assuring~~ ensuring] the development of the POCs for waiver individuals. The director shall assign either himself, the activities director if there is one, RN, or therapist to act as the care coordinator for each waiver individual and shall document in the individual's medical record the identity of the care coordinator. The care coordinator shall be responsible for management of the waiver individual's POC and for its review with the program aides and any other staff, as necessary.

(2) A RN shall be responsible for administering to and monitoring the health needs of [~~the~~] waiver individuals. The RN may also contract with the center. The RN shall be responsible for the planning and implementation of the POC involving multiple services where specialized health care knowledge may be needed. The

RN shall be present a minimum of eight hours each month at the center. DMAS may require the RN's presence at the center for more than this minimum standard depending on the number of waiver individuals who are in attendance and according to the medical and nursing needs of the waiver individuals who attend the center. Although DMAS does not require that the RN be a full-time staff position, there shall be a RN available, either in person or by telephone, to the center's waiver individuals and staff during all times that the center is in operation. The RN shall be responsible for:

(a) Providing periodic evaluation, at least every 90 days, of the nursing needs of each waiver individual;

(b) Providing the nursing care and treatment as documented in individuals' POCs; and

(c) Monitoring, recording, and administering of prescribed medications or supervising the waiver individual in self-administered medication.

(3) Personal care aides [~~who~~] shall be responsible for overall care of waiver individuals such as assistance with ADLs, social/recreational activities, and other health and therapeutic-related activities. Each program aide hired by the provider shall be screened to ensure compliance with training and skill mastery qualifications required by DMAS. The aide shall, at a minimum, have the following qualifications:

(a) Be 18 years of age or older;

(b) Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required waiver individual documentation of services rendered;

(c) Be physically able to perform the work and have the skills required to perform the tasks required in the waiver individual's POC;

(d) Have a valid social security number issued to the program aide by the Social Security Administration;

(e) Have satisfactorily completed an educational curriculum as set out in this subdivision. Documentation of successful completion shall be maintained in the aide's personnel file and be available for review by DMAS' staff. Prior to assigning a program aide to a waiver individual, the center shall ensure that the aide has either (i) registered with the Board of Nursing as a certified nurse aide; (ii) graduated from an approved educational curriculum as listed by the Board of Nursing; or (iii) completed the provider's educational curriculum, at least 40 hours in duration, as taught by an RN who is licensed in the Commonwealth or who holds a multi-state licensing privilege.

(4) The ADHC coordinator shall coordinate, pursuant to 22VAC40-60-695, the delivery of the activities and services as prescribed in the waiver individuals' POCs and keep such plans updated, record 30-day progress notes [concerning each waiver individual] , and review the waiver individuals' daily records each week. If a waiver individual's condition changes more frequently, more frequent reviews and recording of progress notes shall be required to reflect the individual's changing condition.

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

3. The center shall maintain all records of each Medicaid individual. These records shall be reviewed periodically by DMAS staff or its designated agent who is

authorized by DMAS to review these files. At a minimum, these records shall contain, but shall not necessarily be limited to:

a. DMAS required forms as specified in the center's provider-appropriate guidance documents;

b. Interdisciplinary POCs developed, in collaboration with the waiver individual or family/caregiver, or both as may be appropriate, by the center's director, RN, and therapist, as may be appropriate, and any other relevant support persons;

c. Documentation of interdisciplinary staff meetings that shall be held at least every three months to reassess each waiver individual and evaluate the adequacy of the POC and make any necessary revisions;

d. At a minimum, 30-day goal-oriented progress notes recorded by the designated ADHC care coordinator. If a waiver individual's condition and treatment POC changes more often, progress notes shall be written more frequently than every 30 days;

e. The daily record of services provided shall contain the specific services delivered by center staff. The record shall also contain the arrival and departure times of the waiver individual and shall be signed weekly by either the director, activities director, RN, or therapist employed by the center. The 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 waiver individual. 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 shall be given weekly to the waiver individual or family/caregiver; and it shall also be maintained in the waiver individual-specific medical record; and

f. All contacts shall be documented in the waiver individual's medical record, including correspondence made to and from the individual with family/caregivers, physicians, DMAS, the designated [~~PA/Srv Auth~~ Srv Auth]contractor, formal and informal services providers, and all other professionals related to the waiver individual's Medicaid services or medical care.

F. Agency-directed personal care services. The personal care provider agency shall hire or contract with and directly supervise a RN who provides ongoing supervision of all personal care aides and LPNs. LPNs may supervise [, pursuant to their licenses,] personal care aides based upon RN assessment of the waiver individuals' health, safety, and welfare needs.

1. The RN supervisor shall make an initial home assessment visit on or before the start of care for all individuals admitted to personal care [,] when a waiver individual is readmitted after being discharged from services [,] or if he is transferred from another provider, ADHC, or from a CD services program.

2. [~~The~~ During a home visit, the] RN supervisor shall evaluate, at least every [~~six months~~ 90 days] , the LPN supervisor's performance and the waiver individual's needs to ensure the LPN supervisor's abilities to function competently and shall provide training as necessary. This shall be documented in the waiver individual's record. [A reassessment of the individual's needs and review of the POC shall be performed and documented during these visits.]

3. The RN/LPN supervisor shall also make supervisory visits based on the assessment and evaluation of the care needs of waiver individuals as often as needed and as defined in this subdivision to ensure both quality and appropriateness of services.

a. The personal care provider agency shall have the responsibility of determining when supervisory visits are appropriate for the waiver individual's health, safety,

and welfare. Supervisory visits shall be at least every 90 days. This determination must be documented in the waiver individuals' records by the RN on the initial assessment and in the ongoing [assessment] records.

b. If DMAS determines that the waiver individual's health, safety, or welfare is in jeopardy, DMAS may require the provider's RN or LPN supervisor to supervise the personal care aides more frequently than once every 90 days. These visits shall be conducted at this designated increased frequency until DMAS determines that the waiver individual's health, safety, or welfare is no longer in jeopardy. This shall be documented by the provider and entered into the individual's record.

c. During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the individual's current functioning status and medical and social needs. The personal care aide's record shall be reviewed and the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed.

d. If the supervising RN/LPN must be delayed in conducting the regular supervisory visit, such delay shall be documented in the waiver individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the waiver individual's first availability.

e. A RN/LPN supervisor shall be available to the personal care aide for conferences pertaining to waiver individuals being served by the aide.

(1) The RN/LPN supervisor shall be available to the aide by telephone at all times that the aide is providing services to waiver individuals.

(2) The RN/LPN supervisor shall evaluate the personal care aide's performance and the waiver 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 waiver individual's record.

f. Licensed Practical Nurses (LPNs). As permitted by his license, the LPN may supervise personal care aides. To ensure both quality and appropriateness of services, the LPN supervisor shall make supervisory visits of the aides as often as needed, but no fewer visits than provided in waiver individuals' POCs as developed by the RN in collaboration with individuals and the individuals' family/caregivers, or both, as appropriate.

(1) During visits to the waiver individual's home, a LPN-supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services [~~with regard to~~ ,] the individual's current functioning status and social needs. The personal care aide's record shall be reviewed and the waiver individual's or family/caregiver's, or both, satisfaction with the type and amount of services discussed.

(2) The LPN supervisor shall evaluate the personal care aide's performance and the waiver individual's needs to identify any insufficiencies in the aide's abilities to function competently and shall provide training as required to resolve the insufficiencies. This shall be documented in the waiver individual's record and reported to the RN supervisor.

(3) An LPN supervisor shall be available to personal care aides for conferences pertaining to waiver individuals being served by them.

g. Personal care aides. The agency provider [~~shall~~ may] employ and the RN/LPN supervisor shall directly supervise personal care aides who provide direct care to waiver individuals. Each aide hired to provide personal care shall be evaluated by the provider agency to ensure compliance with qualifications and skills required by DMAS pursuant to 12VAC30-120-930.

4. Payment [~~may~~ shall not] be made for services furnished by [family members or] [~~live-in~~] caregivers [~~or family members~~] [who are living under the same roof as the waiver individual receiving services] , [~~other than the (i) spouse of the waiver individual; (ii) parent or parents of the waiver individual; or (iii) legal guardian who are functioning as personal care aides when~~ unless] there is objective written documentation as to why there are no other providers or , aides available to provide the care. [The provider shall initially make this determination and document it fully in the waiver individual's record.]

[~~These family members who may be appropriate to be reimbursed by DMAS for personal care aide services shall meet the same education and physical requirements as aides who are not family members. The provider shall initially make the determination that a family member may be permitted to serve as the personal care aide and document it fully in the waiver individual's record. DMAS shall make the final determination of the appropriateness of such family members providing these services during its reviews.~~]

5. Required documentation for waiver 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 or its designated agent. At a minimum, the record shall contain:

(a) All personal care aides' records (DMAS-90) to include (i) the specific services delivered to the waiver individual by the aide; (ii) the personal care aide's actual daily arrival and departure times; (iii) the aide's weekly comments or observations about the waiver individual, including observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and (iv) any other information appropriate and relevant to the waiver individual's care and need for services.

(b) The personal care aide's and individual's or responsible caregiver's signatures, including the date, shall be recorded on these records verifying that personal care services have been rendered during the week of the service delivery.

(i) An employee of the provider shall not sign for the waiver individual unless he is a family member or unpaid caregiver of the waiver individual.

(ii) Signatures, times, and dates shall not be placed on the personal care aide record earlier than the last day of the week in which services were provided nor later than seven calendar days from the date of the last service.

G. Agency-directed respite care services.

1. To be approved as a respite care provider with DMAS, the respite care agency provider shall:

a. Employ or contract with and directly supervise either a RN or LPN, or both, who will provide ongoing supervision of all respite care aides/LPNs, as appropriate. A RN shall provide supervision to all direct care and supervisory LPNs.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of the required RN/LPN supervisor's visits shall not exceed every 90 days, based on the initial assessment. If an individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visits. However, the RN/LPN supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

(2) When respite care services are not received on a routine basis but are episodic

in nature, a RN/LPN supervisor shall [~~not be required to conduct a supervisory visit within a specified number of days. Instead, a RN/LPN supervisor shall conduct the home supervisory visit with the aide/LPN on or before the start of care and make a second home supervisory visit during the second respite care visit.~~ conduct the home supervisory visit with the aide/LPN on or before the start of care. The RN/LPN shall review the utilization of respite services either every six months or upon the use of half of the approved respite hours, which ever comes first.] If a waiver individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visit.

(3) During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of respite care services [~~with regard~~] to the waiver individual's current functioning status and medical and social needs. The aide's/LPN's record shall be reviewed along with the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed.

(4) Should the required RN/LPN supervisory visit be delayed, the reason for the delay shall be documented in the waiver individual's record. This visit shall be completed within 15 days of the waiver individual's first availability.

b. Employ or contract with aides to provide respite care services who shall meet the same education and training requirements as personal care aides.

c. Not hire respite care aides for DMAS' reimbursement for services that are rendered to waiver individuals when the aide is either (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, legal guardian) or other guardian of the minor child waiver individual.

d. Employ an LPN to perform skilled respite care services. Such services shall be reimbursed by DMAS under the following circumstances:

(1) The waiver individual shall have a documented need for routine skilled respite care that cannot be provided by unlicensed personnel, such as an aide. These waiver individuals would typically require a skilled level of care involving, for example but not necessarily limited to, ventilators for assistance with breathing or either nasogastric or gastrostomy feedings;

(2) No other person in the waiver individual's support system is willing and able to supply the skilled component of the individual's care during the primary caregiver's absence; and

(3) The waiver individual is unable to receive skilled nursing visits from any other source that could provide the skilled care usually given by the caregiver.

e. Document in the waiver individual's record the circumstances that require the provision of services by an LPN. At the time of the LPN's service, the LPN shall also provide all of the services normally provided by an aide.

2. Payment shall not be made for services furnished by other family members or [~~live-in~~] caregivers who are living under the same roof as the waiver individual receiving services unless there is objective written documentation as to why there are no other providers or aides available to provide the care. [The provider shall initially make this determination and document it fully in the waiver individual's record.]

[~~Other family members or live-in caregivers of the waiver individual who are approved to provide paid respite services shall meet the same training and physical standard requirements as those who are employed by an agency. The provider shall initially make this determination and document it fully in the waiver individual's record. DMAS shall make the final determination of the~~

~~appropriateness of such family members providing these services during reviews.~~]

3. Required documentation for waiver individuals' records. The provider shall maintain all records for each waiver individual receiving respite 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 either by the DMAS staff or a contracted entity who is authorized by DMAS to review these files. At a minimum these records shall contain:

a. Forms as specified in the DMAS' guidance documents;

b. All respite care LPN/aide records shall contain:

(1) The specific services delivered to the waiver individual by the LPN/aide;

(2) The respite care LPN's/aide's daily arrival and departure times;

(3) Comments or observations recorded weekly about the waiver individual. LPN/aide comments shall include, but shall not be limited to, observation of the waiver individual's physical and emotional condition, daily activities, the individual's response to services rendered, and documentation of vital signs if taken as part of the POC.

c. All respite care LPN records (DMAS-90A) shall be reviewed and signed by the supervising RN and shall contain:

[~~d~~ (1)] . The respite care LPN/aide's and [waiver] individual's or responsible family/caregiver's signatures, including the date, verifying that respite care services have been rendered during the week of service delivery as documented in the record.

([~~1~~ 2]) An employee of the provider shall not sign for the waiver individual unless he is a family member or unpaid caregiver of the waiver individual.

([~~2~~ 3]) Signatures, times, and dates shall not be placed on the respite care LPN/aide record earlier than the last day of the week in which services were provided [~~nor~~ . Nor] shall signatures be placed on the respite care LPN/aide records later than seven calendar days from the date of the last service.

H. Consumer-directed (CD) services facilitation for personal care and respite services.

1. Any services rendered by attendants prior to dates authorized by DMAS or the [~~PA/Srv Auth~~ Srv Auth] contractor shall not be eligible for Medicaid reimbursement and shall be the responsibility of the waiver individual.

2. The CD services facilitator shall meet the following qualifications:

a. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient knowledge, skills, and abilities to perform the activities required of such providers. In addition, the CD services facilitator shall 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.

[b. 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:

[(1) Knowledge of:

[(a) 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;

[(b) 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;

[(c) 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;

[(d) 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;

[(e) Elderly or Disabled with Consumer-Direction Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

[(f) How to conduct assessments (including environmental, psychosocial, health, and functional factors) and their uses in services planning;

[(g) Interviewing techniques;

[(h) 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;

[(i) The principles of human behavior and interpersonal relationships; and

[(j) General principles of record documentation.

[(2) Skills in:

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

[(b) Assessing, supporting, observing, recording, and reporting behaviors;

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

[(d) Identifying services within the established services system to meet the individual's needs.

[(3) Abilities to:

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

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

[(c) Be persistent and remain objective;

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

[(e) Communicate effectively, orally and in writing; and

[(f) Develop a rapport and communicate with individuals from diverse cultural

backgrounds.]

[~~b~~ c] . If the CD services facilitator is not a RN, the CD services facilitator shall inform the waiver individual's primary health care provider that services are being provided and request consultation as needed. These contacts shall be documented in the waiver individual's record.

3. Initiation of services and service monitoring.

a. For CD services, the CD services facilitator shall make an initial comprehensive in-home visit at the primary residence of the waiver individual to collaborate with the waiver individual or family/caregiver to identify the needs, assist in the development of the POC with the waiver individual or family/caregiver, as appropriate, and provide employer of record (EOR) [employee management] training within seven days of the initial visit. The initial comprehensive home visit shall be conducted only once upon the waiver individual's entry into CD services. If the waiver individual changes, either voluntarily or involuntarily, the CD services facilitator, the new CD services facilitator must complete a reassessment visit in lieu of an initial comprehensive visit.

b. After the initial comprehensive visit, the CD services facilitator shall continue to monitor the POC on an as-needed basis, but in no event less frequently than every 90 days for personal care, and shall conduct face-to-face meetings with the waiver individual and [may include the] family/caregiver. The CD services facilitator shall review the utilization of CD respite services, either every six months or upon the use of half of the approved respite services hours, whichever comes first, and shall conduct a face-to-face meeting with the waiver individual [~~or~~ and may include the] family/caregiver [~~, or both~~] .

c. During visits with the waiver individual, the CD services facilitator shall observe, evaluate, and consult with the [~~individual~~ individual/EOR ~~or~~ and may include the] family/caregiver, and document the adequacy and appropriateness of CD services with regard to the waiver individual's current functioning, cognitive status, and medical and social needs. The CD services facilitator's written summary of the visit shall include, but shall not necessarily be limited to:

(1) A discussion with the waiver individual or family/caregiver/EOR concerning whether the service is adequate to meet the waiver individual's needs;

(2) Any suspected abuse, neglect, or exploitation and to whom it was reported;

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

(4) The waiver individual's or family/caregiver's/EOR's satisfaction with the service;

(5) Any hospitalization or change in medical condition, functioning, or cognitive status; and

(6) The presence or absence of the attendant in the home during the CD services facilitator's visit.

4. DMAS, its designated contractor, or the fiscal/employer agent shall request a criminal record check and a check of the VDSS Child Protective Services Central Registry [if the waiver individual is a minor child] , in accordance with 12VAC30-120-930, pertaining to the attendant on behalf of the waiver individual and report findings of these records checks to the [~~waiver individual or the family/caregiver or~~] EOR.

5. The CD services facilitator shall review copies of timesheets during the face-to-face visits to ensure that the hours approved in the POC are being provided and are not exceeded. If discrepancies are identified, the CD services facilitator shall discuss these with the waiver individual [~~, family/caregiver,~~] or EOR to resolve

discrepancies and shall notify the fiscal/employer agent. The CD services facilitator shall also review the waiver individual's POC to [~~assure~~ ensure] that the waiver individual's needs are being met.

6. The CD services facilitator shall maintain records of each waiver individual that he serves. At a minimum, these records shall 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 POC [~~goals, objectives, and activities~~] . Such plans shall be reviewed by the provider every 90 days, annually, and more often as needed, and modified as appropriate. [~~Respite~~ The respite services] POC [~~goals, objectives, and activities~~ shall be included in the record and] shall be reviewed by the provider every six months or when half of the approved respite service hours have been used [which ever comes first] . For the annual review and in cases where [either] the [personal care or respite care] POC is modified, the POC shall be reviewed with the waiver individual, the family/caregiver, and EOR, as appropriate;

c. CD services facilitator's dated notes documenting any contacts with the waiver individual or family/caregiver/EOR and visits to the individual;

d. All contacts, including correspondence, made to and from the waiver individual, [~~with~~ EOR,] family/caregiver, physicians, DMAS, the designated [~~PA/Srv Auth~~ Srv Auth]contractor, formal and informal services provider, and all other professionals related to the individual's Medicaid services or medical care;

e. All employer management training provided to the waiver individual or [~~family/caregiver/EOR~~ EOR] to include, but not necessarily be limited to (i) the individual's or [~~family/caregiver's/EOR's~~ EOR's] receipt of training on their responsibilities for the accuracy of the attendant's timesheets and (ii) the availability of the Consumer-Directed Waiver Services Employer Manual available at www.dmas.virginia.gov;

f. All documents signed by the waiver individual [~~, the family/caregiver,~~] or EOR, as appropriate, that acknowledge the responsibilities as the employer; and

g. The DMAS required forms as specified in the agency's waiver-specific guidance document.

[~~7. Waiver individuals shall not employ attendants for DMAS reimbursement for services rendered to themselves when the attendant is (i) the spouse of the waiver individual; (ii) parent (biological, adoptive, legal guardian) or other guardian of the minor-child waiver individual; or (iii) family/caregiver or caregivers/EOR who may be directing the waiver individual's care.~~]

[~~8.~~7.] Payment shall not be made for services furnished by [~~other family/caregiver/EOR~~ family members or caregivers who are] living under the same roof as the waiver individual [~~being served~~ receiving services] unless there is objective written documentation by the CD services facilitator as to why there are no other providers [or aides] available to provide the required care. [~~Other members /caregivers living under the same roof] who are approved to provide paid attendant services shall meet the previously specified education [, training,] and physical qualifications for attendants.~~] The CD services facilitator shall [initially] make [~~and document the~~ this] determination [~~that specific other family members caregivers can be permitted to be paid attendants~~ and document it fully in the waiver individual's record] . [~~DMAS staff shall also review and make a final determination of the appropriateness of such family members / or caregivers to provide these services during provider reviews.~~]

[~~9.~~8.] In instances when either the waiver individual is consistently unable to hire

and retain the employment of a personal care attendant to provide CD personal care or respite services such as, but not limited to, a pattern of discrepancies with the attendant's timesheets, the CD services facilitator shall make arrangements, after conferring with DMAS, to have the needed services transferred to an agency-directed services provider of the individual's choice or discuss with the waiver individual or family/caregiver/EOR, or both, other service options.

10. Waiver individual responsibilities.

a. The waiver individual shall be authorized for CD services and [the EOR shall] successfully complete [~~consumer/management~~ consumer/employee-management] training performed by the CD services facilitator before the individual shall be permitted to hire [~~a personal care~~ an] attendant for Medicaid reimbursement. Any services that may be rendered by an attendant prior to authorization by Medicaid shall not be eligible for reimbursement by Medicaid. Waiver individuals who are eligible for CD services shall have the capability to hire and train their own [~~personal care~~] attendants and supervise the attendants' performance. Waiver individuals ~~[with cognitive impairments who are unable to manage their own care]~~ may have a family/caregiver [or other designated person] serve as the EOR on their behalf. The [~~family/caregiver who serves as the~~] EOR [~~on behalf of the waiver individual~~] shall be prohibited from also being the Medicaid-reimbursed attendant for respite or personal care or the services facilitator for the waiver individual.

b. Waiver individuals shall acknowledge that they will not knowingly continue to accept CD personal care services when the service is no longer appropriate or necessary for their care needs and shall inform the services facilitator of their change in care needs. If CD services continue after services have been terminated by DMAS or the designated [~~PA/Srv Auth~~ Srv Auth] contractor, the waiver individual shall be held liable for attendant compensation.

c. Waiver individuals shall notify the CD services facilitator of all hospitalizations or admissions, such as but not necessarily limited to, to any rehabilitation facility [~~or~~ ,] rehabilitation unit or NF as CD attendant services shall not be reimbursed during such admissions. Failure to do so may result in the waiver individual being held liable for attendant compensation.

[d. Waiver individuals shall not employ attendants for DMAS reimbursement for services rendered to themselves when the attendant is the (i) spouse of the waiver individual; (ii) parent (biological, adoptive, legal guardian) or other guardian of the minor-child waiver individual; or (iii) family/caregiver or caregivers/EOR who may be directing the waiver individual's care.]

l. Personal emergency response systems. 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 and requirements:

1. A PERS provider shall be either, but not necessarily limited to, a personal care agency, a durable medical equipment provider, 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 shall provide an emergency response center with fully trained operators who are capable of (i) receiving signals for help from an individual's PERS equipment 24 hours a day, 365 or 366 days per year, as appropriate; (ii) determining whether an emergency exists; and (iii) notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help;

3. A PERS provider shall 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 shall have 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 waiver individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit and shall provide temporary equipment, as may be necessary for the waiver individual's health, safety, and welfare, while the original equipment is being repaired [or replaced] ;

5. The PERS provider shall install, consistent with the manufacturer's instructions, all PERS equipment into a waiver individual's functioning telephone line or system within seven days of the request of such installation unless there is appropriate documentation of why this timeframe cannot be met. The PERS provider shall furnish all supplies necessary to ensure that the system is installed and working properly. The PERS provider shall 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 shall 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 shall maintain a data record for each waiver individual at no additional cost to DMAS or the waiver individual. The record shall document all of the following:

a. Delivery date and installation date of the PERS equipment;

b. Waiver [~~individual/caregiver/EOR~~ individual/caregiver] signature verifying receipt of the PERS equipment;

c. Verification by a test that the PERS device is operational and the waiver individual is still using it monthly or more frequently as needed;

d. Waiver individual contact information, to be updated annually or more frequently as needed, as provided by the individual or the individual's caregiver/EOR;

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

f. Documentation that the waiver individual is able to use the PERS equipment through return demonstration; and

g. Copies of all equipment checks performed on the PERS unit;

8. The PERS provider shall have backup monitoring capacity in case the primary system cannot handle incoming emergency signals;

9. The emergency response activator shall be capable of being activated either by breath, touch, or some other means and shall be usable by waiver individuals who are visually or hearing impaired or physically disabled. The emergency response communicator shall be capable of operating without external power during a power failure at the waiver individual's home for a minimum period of 24 hours. The emergency response console unit shall also be able to self-disconnect and redial the backup monitoring site without the waiver individual resetting the system in the event it cannot get its signal accepted at the response center;

10. PERS providers shall be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to ensure that the

monitoring agency and the monitoring agency's equipment meets the following requirements. The PERS provider shall be capable of simultaneously responding to multiple signals for help from the waiver individuals' PERS equipment. The PERS provider's equipment shall include the following:

a. A primary receiver and a backup receiver, which shall be independent and interchangeable;

b. A backup information retrieval system;

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

d. A backup 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 backup response center; and

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

11. The PERS provider shall 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;

12. 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 waiver individual. This excludes test signals or activations made in error. This written report shall be furnished to (i) the personal care provider; (ii) the respite care provider; (iii) the CD services facilitation provider; (iv) in cases where the individual only receives ADHC services, to the ADCC provider; or (v) to the transition coordinator for the service in which the individual is enrolled; and

13. The PERS provider shall obtain and keep on file a copy of the most recently completed DMAS-225 form. Until the PERS provider obtains a copy of the DMAS-225 form, the PERS provider shall clearly document efforts to obtain the completed DMAS-225 form from the personal care provider, respite care provider, CD services facilitation provider, or ADCC provider.

J. Assistive technology (AT) and environmental modification (EM) services. AT and EM shall be provided only to waiver individuals who also participate in the MFP demonstration program by providers who have current provider participation agreements with DMAS. [~~AT shall be provided consistent with the limits contained in 12VAC30-120-762. EM shall be provided consistent with the limits contained in 12VAC30-120-758.~~]

1. AT shall be rendered by providers having a current provider participation agreement with DMAS as durable medical equipment and supply providers. An independent, professional consultation shall be obtained, as may be required, from qualified professionals who are knowledgeable of that item for each AT request prior to approval by either DMAS or the [~~PA/Serv Auth~~ Srv Auth] agent and may include training on such AT by the qualified professional. Independent, professional consultants shall include, but shall not necessarily be limited to, speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Providers that supply AT for a waiver individual may not perform assessment/consultation, write specifications, or inspect the AT for that individual. Providers of services shall not be (i) spouses of the waiver individual or

(ii) parents (biological, adoptive, foster, or legal guardian) of the waiver individual. AT shall be delivered within [~~a year~~ 60 days] from the start date of the authorization. [The AT provider shall ensure that the AT functions properly.]

2. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-930, as appropriate, environmental modifications shall be provided in accordance with all applicable state or local building codes by contractors who have [~~a~~] provider [~~agreement~~ agreements] with DMAS. Providers of services shall not be (i) spouses of the waiver individual or (ii) the parent (biological, adoptive, foster, or legal guardian) of the waiver individual [who is a minor child] . Modifications shall be completed within a year of the start date of the authorization.

3. Providers of AT and EM services shall not be permitted to recover equipment that has been provided to waiver individuals whenever the provider has been charged, by either DMAS or its designated service authorization agent, with overpayments and is therefore being required to return payments to DMAS.

K. Transition coordination. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.

L. Transition services. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.

12VAC30-120-940
12VAC30-120-940. ~~Adult day health care services.~~ (Repealed.)

~~A. This section contains specific requirements governing the provision of adult day health care (ADHC).~~

~~B. 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.~~

~~C. 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. Adhere to and meet the following DMAS special participation standards that are imposed in addition to DSS standards:~~

~~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. Maintain a minimum staff-to-participant ratio of at least one staff member to every six participants. This includes Medicaid and other participants;~~

~~d. Provide 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, designate the activities director, registered nurse, or therapist to supervise the program;~~

~~f. May include volunteers in the staff-to-participant ratio if these volunteers meet~~

~~the qualifications and training requirements for compensated employees, and, for each volunteer so counted, include at least one compensated employee in the staff-to-participant ratio;~~

~~g. For any center that is co-located with another facility, count only its own separate identifiable staff in the center's staff-to-participant ratio; and~~

~~h. 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.~~

~~(a) 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.~~

~~(b) 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) 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:~~

~~(a) Have a minimum of 48 semester hours or 72 quarter hours of postsecondary 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; and~~

~~(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.~~

~~(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:~~

~~(a) Be at least 10 years of age or older;~~

~~(b) Be able to read and write in English to the degree necessary to perform the tasks expected;~~

~~(c) Be physically able to do the work;~~

~~(d) 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) A registered nurse (RN) employed or contracted with the center 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:~~

~~(a) Be registered and licensed as a registered nurse to practice nursing in the Commonwealth; and~~

~~(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.~~

~~D. 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. Providing periodic evaluation of the nursing needs of each participant;~~

~~b. Providing 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 that 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.~~

~~E. 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 DMAS to review these files. At a minimum, these records shall contain:~~

~~1. The Long-Term Care Uniform Assessment Instrument, the Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96), the Screening Team Plan of Care for Medicaid-Funded Long-Term Care form (DMAS-97), the DMAS-101A and the DMAS-101B forms (if applicable), and the most recent patient information from the DMAS-122 form;~~

~~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 that 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 rehabilitative progress report and updated treatment plan from all professional disciplines involved in the participant's care obtained 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.~~

12VAC30-120-945
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-945. Payment for covered services.

A. DMAS shall not reimburse providers, either agency-directed or consumer-directed, for any staff training required by these waiver regulations or any other training that may be required.

B. All services provided in the EDCD Waiver shall be reimbursed at a rate established by DMAS in its agency fee schedule.

1. DMAS shall reimburse a per diem fee for ADHC services that shall be considered as payment in full for all services rendered to that waiver individual as part of the individual's approved ADHC plan of care.

2. Agency personal care/respite care services shall be reimbursed on an hourly basis consistent with the agency's fee schedule.

3. Consumer-directed personal care/respite care services shall be reimbursed on an hourly basis consistent with the agency's fee schedule.

4. Transition Services. The total costs of these transition services shall be limited to $5,000 per waiver individual per lifetime and shall be expended within nine months from the [start] date of authorization.

5. Reimbursement for assistive technology (AT) and environmental modification (EM) services shall be limited to those waiver individuals who are also [~~receiving transition coordination services and shall be limited as follows~~ participating in the MFP demonstration program] :

a. All AT services provided in the EDCD Waiver shall be reimbursed as a service limit of one. AT services in this waiver shall be reimbursed up to a per individual annual MFP enrollment period not to exceed 12 months [~~pursuant to 12VAC30-120-762~~] . These limits shall apply regardless of whether the waiver individual remains in this waiver or changes to another waiver program.

b. All EM services provided in the EDCD Waiver shall be reimbursed [~~pursuant to 12VAC30-120-758~~] per individual annual MFP enrollment period not to exceed 12 months [~~regardless of waiver year as long as such services are not duplicative~~] . All EM services shall be reimbursed at the actual cost of material and labor and no mark ups shall be permitted.

[~~c. Providers of all EDCD Waiver AT and EM services shall not be permitted to recover any equipment that has been provided to waiver individuals subsequent to provider audits in which DMAS or its designated contractor has recovered payments made to providers.~~]

6. DMAS shall reimburse a monthly fee for transition coordination consistent with the agency's fee schedule.

7. PERS monthly fee payments shall be consistent with the agency's fee schedule.

C. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the American with Disabilities Act (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, or the Virginians with Disabilities Act.

2. Payment for waiver services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. All private insurance benefits for these waiver covered services shall be exhausted before Medicaid reimbursement can occur as Medicaid shall be the payer of last resort.

3. DMAS payments for EM services shall not be duplicative in homes where multiple waiver individuals reside. [~~For example, one waiver individual may be approved for required medically necessary bathroom modifications while a second waiver individual in the same household would be approved for a medically necessary access ramp but not additional improvements to the same bathroom.~~]

12VAC30-120-950
12VAC30-120-950. ~~Agency-directed personal care services.~~ (Repealed.)

~~A. This section contains requirements governing the provision of agency-directed personal care services.~~

~~B. 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 (e.g., catheterization) that may be delegated pursuant to 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.~~

~~1. Effective July 1, 2011, agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year.~~

~~2. Individual exceptions may be granted based on criteria established by DMAS.~~

~~C. 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 postsecondary 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 postsecondary 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 postsecondary school functions or for supervision time during work or school or both.~~

~~4. There shall be a limit of eight 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.~~

~~D. Special provider participation conditions. The personal care provider shall:~~

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

~~2. Employ persons 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. Hire employees (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 program.~~

~~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, and 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 the 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.~~

~~4. 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 at least 18 years of age or older;~~

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

~~c. 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;~~

~~d. Be physically able to do the work; and~~

~~e. Not be (i) the parents of minor children who are receiving waiver services or (ii) spouses of individuals who are receiving waiver services.~~

~~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.~~

~~E. 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 nonhome 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 Service Authorization Form (DMAS-96), the Screening Team Plan of Care for Medicaid-Funded Long-Term Care (DMAS-97), all Provider Agency Plans of Care (DMAS-97A), 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.~~

12VAC30-120-960
12VAC30-120-960. ~~Agency-directed respite care services.~~ (Repealed.)

~~A. This section contains requirements governing the provision of agency-directed respite care services.~~

~~B. 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 (e.g., catheterization) that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.~~

~~C. General. Respite care may only be offered to individuals who have a primary caregiver 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 480 hours per year per individual effective July 1, 2011. Reimbursement shall be made on an hourly basis.~~

~~D. 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 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. 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 and 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 aide has satisfactorily completed a training program consistent with DMAS standards; and~~

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

~~Respite care aides may not be the parents of minor children who are receiving waiver services or spouses of individuals who are receiving waiver services. 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 that 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; and~~

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

~~The provider must document in the individual's record the circumstances that require the provision of services by an LPN. When an LPN is required, the LPN must also provide any of the services normally provided by an aide.~~

~~E. 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 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 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 Service 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; and~~

~~e. All individual progress reports.~~

~~Documentation signed by the LPN must be reviewed and signed by the supervising RN.~~

12VAC30-120-970

12VAC30-120-970. ~~Personal emergency response system (PERS).~~ (Repealed.)

~~A. Service description. PERS is a service that 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 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 equals the one-month rental of PERS, the price of which 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 12VAC30-120-80, 12VAC30-120-160, and 12VAC30-120-930, PERS providers must also meet the following qualifications and requirements:~~

~~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 (i) receiving signals for help from an individual's PERS equipment 24 hours a day, 365 or 366 days per year as appropriate; (ii) determining whether an emergency exists; and (iii) 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 backup 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 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 backup battery is low. The emergency response console unit must also be able to self-disconnect and redial the backup 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 backup receiver, which must be independent and interchangeable;~~

~~b. A backup 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 backup 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 backup 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 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 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, the transition coordinator, case manager, as appropriate to the waiver in which the individual is enrolled 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 form, the PERS provider must clearly document efforts to obtain the completed DMAS-122 form from the personal care provider, respite care provider, the CD services facilitation provider, the transition coordinator, the case manager, or the ADHC provider, as appropriate to the waiver in which the individual is enrolled.~~

12VAC30-120-980
12VAC30-120-980. ~~Consumer-directed services: personal care and respite services.~~ (Repealed.)

~~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 (e.g., catheterization) that may be delegated pursuant to 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 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 services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed services. The CD services 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 services 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 12VAC30-120-900.~~

~~2. Consumer-directed respite services may only be offered to individuals who have an unpaid primary caregiver 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 postsecondary 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 postsecondary 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 postsecondary 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 references of personal care aides, determining that personal care aides meet basic qualifications, and maintaining copies of timesheets to have available for review by the CD services facilitator and the fiscal agent on a consistent and timely basis. The individual or family/caregiver must have a backup 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. Effective July 1, 2011, consumer-directed respite services are limited to a maximum of 480 hours per year. Individuals who receive consumer-directed respite services, agency-directed respite services or facility-based respite services, or both, may not receive more than 480 hours combined, regardless of service delivery method.~~

~~2. The unit of service for consumer-directed personal care services is one hour. Effective July 1, 2011, these personal care services shall be limited to 56 hours per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.~~

~~D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-930, 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 services facilitator will be responsible;~~

~~(6) How to conduct 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 facilitator, 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 and medical and social needs. The CD services facilitator's written summary of the visit must include, but is not necessarily limited to:~~

~~a. A discussion with the individual or family/caregiver concerning 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. The 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 on the date that the criminal record check confirms an aide has been found to have been convicted of a crime as described in § 32.1-162.9:1 of the Code of Virginia or if the aide has a confirmed record on the DSS Child Protective Services Central Registry.~~

~~8. The CD services 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 services 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 240 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 or 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 Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96), the Screening Team Plan of Care form (DMAS-97), all Consumer-Directed Personal Assistance Plans of Care forms (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;~~

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

~~e. Possess a valid Social Security number;~~

~~f. 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 § 32.1-162.9:1 of the Code of Virginia or if the aide has a founded complaint confirmed by the DSS Child Protective Services Central Registry;~~

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

~~h. Understand and agree to comply with the DMAS Elderly or Disabled with~~

~~Consumer Direction Waiver requirements; and~~

~~i. Receive periodic tuberculosis (TB) screening.~~

~~11. Aides may not be the parents of minor children who are receiving waiver services or the spouse of the indiviudals who are receiving waiver services 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 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.~~

12VAC30-120-990
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-990. Quality management review; utilization review; level of care (LOC) reviews.

A. DMAS shall perform quality management reviews for the purpose of assuring high quality of service delivery consistent with the attending physicians' orders, approved POCs, [~~prior~~ service] authorized services for the waiver individuals, and DMAS' compliance with CMS assurances. Providers identified as not [~~rendering reimbursed services~~ meeting the standards] consistent with such orders, POCs, and [~~prior~~ service] authorizations shall be required to submit corrective action plans (CAPs) to DMAS for approval. Once approved, such CAPs shall be implemented to resolve the cited deficiencies.

B. If [~~the~~] DMAS staff determines, during any review or at any other time, that the waiver individual no longer meets the criteria for participation in the waiver

(such as functional dependencies, medical/nursing needs, risk of NF placement, or Medicaid financial eligibility), then [~~the~~] DMAS staff, as appropriate, shall deny payment for waiver services for such waiver individuals and they shall be discharged from the waiver.

C. Securing [~~PA~~ service authorization] shall not necessarily guarantee reimbursement pursuant to DMAS utilization review of waiver services.

D. Failure to meet documentation requirements and supervisory reviews in a timely manner may result in either a plan of corrective action or retraction of payments.

E. Once waiver enrollment occurs, Level of Care Eligibility Re-determination audits (LOCERI) shall be performed at DMAS.

1. This independent electronic calculation of eligibility determination is performed and communicated to the DMAS supervisor. Any individual whose LOCERI audit shows failure to meet eligibility criteria shall receive a second manual review and may receive a home visit by DMAS staff.

2. The agency provider and the CD services facilitator shall submit to DMAS upon request an updated DMAS-99 C form, [information from] a current DMAS-97 A/B form, and, if applicable, the DMAS-225 form for designated waiver individuals. This information is required by DMAS to assess the waiver individual's ongoing need for Medicaid-funded long-term care and appropriateness and adequacy of services rendered.

F. DMAS or its designated agent shall periodically review and audit providers' records for these services for conformance to regulations and policies and concurrence with claims that have been submitted for payment. When a waiver individual is receiving multiple services, the records for all services shall be separated from those of non-home and community-based care services, such as companion or home health services. Failure to maintain the required documentation may result in DMAS' determination of overpayments against providers and requiring such providers to repay these overpayments pursuant to § 32.1-325.1 of the Code of Virginia.

12VAC30-120-995
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-995. Appeals.

A. Providers shall have the right to appeal actions taken by DMAS. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (§ 2.2-4000 et seq.) of the Code of Virginia and DMAS regulations at 12VAC30-10-1000 and Part VII (12VAC30-20-500 et seq.) of 12VAC30-20.

B. Individuals shall have the right to appeal actions taken by DMAS. Individuals' appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-370. DMAS shall provide the opportunity for a fair hearing, consistent with 42 CFR Part 431, Subpart E.

C. The individual shall be advised in writing of such denial and of his right to appeal consistent with DMAS client appeals regulations 12VAC30-110-70 and 12VAC30-110-80.

12VAC30-120-9998
FORMS (12VAC30-120)

Virginia Uniform Assessment Instrument (UAI) (1994).

Consent to Exchange Information, DMAS-20 (rev. 4/03).

Provider Aide/LPN Record Personal/Respite Care, DMAS-90 (rev. [~~12/02~~ 06/12]).

LPN Skilled Respite Record, DMAS-90A (eff. 7/05).

Personal Assistant/Companion Timesheet, DMAS-91 (rev. 8/03).

Questionnaire to Assess an Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum ([~~eff. 8/00~~ rev 08/05]).

~~Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 10/06).~~

~~Screening Team Plan of Care for Medicaid-Funded Long Term Care, DMAS-97 (rev. 12/02).~~

~~Provider Agency Plan of Care, DMAS-97A (rev. 9/02).~~

~~Consumer Directed Services Plan of Care, DMAS-97B (rev. 1/98).~~

~~Community-Based Care Recipient Assessment Report, DMAS-99 (rev. 4/03).~~

Medicaid Funded Long-term Care Service Authorization Form, DMAS-96 (rev. 8/12).

Individual Choice - Institutional Care or Waiver Services Form, DMAS-97 (rev. 8/12).

Agency or Consumer Direction Provider Plan of Care, DMAS-97A/B (rev. 3/10).

Community-based Care Recipient Assessment Report, DMAS-99 (rev. 9/09).

[~~Consumer-Directed Personal Attendant Services Recipient Assessment Report, DMAS-99B (rev. 8/03).~~]

[~~MI/MR Level I Supplement for EDCD Waiver Applicants, DMAS-101A (rev. 10/04).~~]

[~~Assessment of Active Treatment Needs for Individuals with MI, MR, or RC Who Request Services under the Elder or Disabled with Consumer-Direction Waivers, DMAS-101B (rev. 10/04).~~]

~~[AIDS Waiver Evaluation Form for Enteral Nutrition, DMAS-116 (6/03).]~~

~~Medicaid Long Term Care Communication Form, DMAS-225 (3/09).~~

Medicaid Long-Term Care Communication Form, DMAS-225 (rev.10/11).

Technology Assisted Waiver/EPSDT Nursing Services Provider Skills Checklist for Individuals Caring for Tracheostomized and/or Ventilator Assisted Children and Adults, DMAS-259.

Home Health Certification and Plan of Care, CMS-485 (rev. 2/94).

IFDDS Waiver Level of Care Eligibility Form (eff. 5/07).