12 VAC 30-120-1600. Definitions.

The following words or terms when used in this regulation shall have the following meanings unless the content clearly indicates otherwise.

"Activities of daily living" or "ADLs" means 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.

"Administrator" means the person who oversees the day-to-day operation of the facility, including compliance with all regulations for licensed assisted living facilities.

"Alzheimer's and Related Dementias Assisted Living Waiver" or "AAL Waiver" means the CMS-approved waiver that covers a range of community support services offered to individuals who have a diagnosis of Alzheimer's or a related dementia who meet nursing facility level of care.

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

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12 VAC 30-110 and 12 VAC 30-20-500 through 12 VAC 30-20-560.

"Assisted living facility" means a congregate residential setting as defined in § 63.2-100 of the Code of Virginia.

"Auxiliary Grant Program" means a state and locally funded assistance program to supplement the income of a Supplemental Security Income (SSI) recipient or an adult

who would be eligible for SSI except for excess income and who resides in a licensed assisted living facility with an approved rate.

"Barrier crime" means those crimes as defined in § 32.1-162.9:1 of the Code of Virginia.

"Comprehensive assessment" means the Virginia Uniform Assessment Instrument and other relevant social, psychological and medical information gathered by the assisted living facility staff for use in the development and updates of the plan of care.

"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.

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

"DMAS" means the Department of Medical Assistance Services.

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

"DSS" means the Department of Social Services.

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

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

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

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

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

"Preadmission screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening; (ii) assist individuals in determining what specific services the individuals need; (iii) evaluate whether a service or a combination of existing community services are available to meet the

individuals' needs; and (iv) refer individuals to the appropriate provider for Medicaid-funded nursing facility or home and community-based care for those individuals who meet nursing facility level of care.

"Preadmission screening team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Related dementia" means a diagnosis of Dementia of the Alzheimer's Type as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV-TR), published by the American Psychiatric Association.

"Resident" means any individual who (i) meets the eligibility criteria for residing in a safe, secure environment as described in 22 VAC 40-71-700 C 1; (ii) meets eligibility criteria for the AAL Waiver; and (iii) resides in a safe, secure environment of an assisted living facility.

"Safe, secure environment" means a self-contained special care unit as defined in 22 VAC 40-71-10.

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

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that is completed by the preadmission screening team, which assesses an individual's physical health, mental health, social, and functional

abilities to determine if the individual meets the level of care for certain publicly funded long-term care programs such as nursing facility services.

12 VAC 30-120-1610. Individual eligibility requirements.

A. Waiver service population. The AAL Waiver shall be available through a § 1915(c) of the Social Security Act waiver to eligible aged and disabled auxiliary grant recipients who reside in licensed assisted living facilities.

B. Eligibility criteria. To qualify for AAL Waiver services, individuals must meet all of the following criteria:

1. The individual must be either:

   a. Elderly as defined by § 1614 of the Social Security Act; or

   b. Disabled as defined by § 1614 of the Social Security Act.

2. The individual must meet the criteria for admission to a nursing facility as determined by a preadmission screening team using the full UAI.

3. The individual must have a diagnosis of Alzheimer's or a related dementia as diagnosed by a licensed clinical psychologist or a licensed physician. The individual may not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation in Mental Retardation –

Definition, Classifications and Systems of Supports, 10th Edition, or a serious mental illness as defined in 42 CFR 483.102(b).

4. The individual must be receiving an auxiliary grant, and residing in or seeking admission to a safe, secure unit of a DMAS-approved assisted living facility.

C. Assessment. Medicaid will not pay for any AAL Waiver services delivered prior to the date of the preadmission screening by the preadmission screening team and the physician signature on the Medicaid-Funded Long-Term Care Services Authorization Form (DMAS-96). Medicaid will not pay for any AAL Waiver services delivered prior to the individual's establishment of Medicaid eligibility.

D. Enrollment. After an initial 60-day application period and a random selection process to determine the order in which eligible individuals will be served by this waiver, individuals will be served on a first-come, first-served basis in accordance with available waiver funding. If there is not a waiver slot available for an individual, the individual shall be placed on the waiting list. Individuals must meet all waiver eligibility criteria in order to be placed on the waiting list.

E. Preauthorization. Before a provider can bill DMAS for AAL Waiver services, preauthorization must be obtained from DMAS. Providers must submit all required information to the designated preauthorization contractor within 10 business days of initiating care. If the provider submits all required information to the designated preauthorization 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). If the provider does not submit all required information to the designated preauthorization contractor within 10 business days of initiating care, the services may be authorized beginning with the date all required information was received by the designated preauthorization contractor, but in no event preceding the date of the preadmission screening team physician's signature on the DMAS-96.

F. Review of level of care. DMAS conducts this review based on the documentation submitted by the provider. The level of care assessments are performed to ensure that individuals receiving services in the waiver continue to meet the criteria for the waiver.

G. Termination of services. In the case of termination of AAL Waiver services by DMAS, individuals shall be notified of their appeal rights pursuant to 12 VAC 30-110, Eligibility and Appeals. DMAS may terminate AAL Waiver care services for any of the following reasons:

1. The AAL Waiver is no longer required to prevent or delay institutional placement;

2. The individual is no longer eligible for Medicaid;

3. The individual is no longer eligible to receive an auxiliary grant;

4. The individual no longer meets AAL Waiver criteria;

5. The individual has been absent from, or has not received services from, the assisted living facility for more than 30 consecutive days;

6. The individual's environment does not provide for his health, safety, and welfare; or

7. The assisted living facility no longer meets safe and secure licensing standards set by VDSS or standards set by DMAS for service providers.

12 VAC 30-120-1620. Covered services.

A. Assisted living services include personal care and services, homemaker, chores, attendant care, and companion services. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

B. For purposes of these regulations, assisted living services shall also include:

1. Medication administration. Medications shall be administered only by an individual currently licensed to administer medications (physician, physician assistant, pharmacist, nurse practitioner, RN, or LPN), except on the 11 p.m. to 7 a.m. shift when medications may be administered by a medication aide that meets the regulatory requirements as set forth by the Department of Social Services and the Board of Nursing;

2. Nursing evaluations. The RN must complete a comprehensive assessment of each resident upon admission and when a significant change in health status or behavior occurs in one of the following areas: weight loss, elopements, behavioral symptoms, or adverse reactions to prescribed medication. A RN shall identify resident care problem areas and formulate interventions to address those problems and to evaluate if the planned interventions were successful;

3. Skilled nursing services. Skilled nursing services are nursing services that are used to complete resident assessments and administer medications, and provide training, consultation, and oversight of direct care staff. Skilled nursing services must be provided by a RN or by a LPN under the supervision of a RN who is licensed to

practice in the state and provided in accordance and within the scope of practice specified by state law; and

4. Therapeutic social and recreational programming. An activity program must be designed to meet the individual needs of each resident and to provide daily activities appropriate to residents with dementia.

a. This program shall be individualized and properly implemented, followed, and reviewed as changes are needed.

b. Residents who have wandering behaviors shall have an activity program to address these behaviors.

c. There shall be a minimum of 19 hours of planned group programming each week, not to include activities of daily living.

d. Each resident must receive at least one hour of one-on-one activity per week, not to include activities of daily living. This activity must be provided exclusively by activities staff.

e. Group activities must be provided by staff assigned responsibility for the activities.

12 VAC 30-120-1630. General requirements for participating providers.

A. Requests for participation will be screened by DMAS to determine whether the provider applicant meets the requirements for participation. Requests for participation must be accompanied by verification of the facility's current licensure from VDSS.

B. For DMAS to approve provider agreements with AAL Waiver providers, providers must meet staffing, financial solvency and disclosure of ownership requirements.

1. Approved providers must assure freedom of choice to individuals, or their authorized representative, 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;

2. Approved providers must assure the individual's freedom to refuse medical care, treatment, and services;

3. Approved providers must accept referrals for services only when staff is available to initiate and perform such services on an ongoing basis;

4. Approved providers must provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000 et seq.), which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973 (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;

5. Approved providers must provide services and supplies to individuals of the same quality as[~~is~~ are] provided to the general public;

6. Approved providers must 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 beginning with the individual's authorization date for the waiver services;

7. Approved providers must use only DMAS-designated forms for service documentation. The provider must not alter the DMAS forms in any manner unless approval from DMAS is obtained prior to using the altered forms. If there is no designated DMAS form for service documentation, the provider must include all elements required by DMAS in the provider's service documentation;

8. Approved providers must use DMAS-designated billing forms for submission of charges;

9. Approved providers must perform no direct marketing activities to Medicaid individuals;

10. Approved providers must maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided;

a. In general, such records shall be retained for at least six years from the last date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved.

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 storage location, as well as the agent or trustee, shall be within the Commonwealth;

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

12. Approved providers must 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;

13. Pursuant to 42 CFR 431.300 et seq., 12 VAC 30-20-90, and any other applicable federal or state law, all providers shall hold confidential and use for authorized DMAS purposes only all medical assistance information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits, or the data is necessary for the functioning of DMAS in conjunction with the cited laws;

14. Approved providers must notify DMAS in writing as least 15 days before ownership or management of the facility changes;

15. Pursuant to § 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that an AAL Waiver services individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or

exploitation must report this immediately from first knowledge to the local DSS or adult protective services hotline as applicable;

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

17. 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 that is 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 § 63.2-1720 of the Code of Virginia regarding criminal record checks; and

18. Approved providers must immediately notify DMAS, in writing, of any change in the information that the provider previously submitted to DMAS.

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

D. 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 of the conviction, notify the Virginia Medicaid Program and relinquish the provider agreement.

E. Provider's Responsibility for the Patient Information Form (DMAS-122). It shall be the responsibility of the service provider to notify VDSS and DMAS, in writing, when any of the following circumstances occur:

1. AAL Waiver services are implemented;

2. An individual dies;

3. An individual is discharged from the provider; or

4. Any other circumstances (including hospitalization) that cause AAL Waiver services to cease or be interrupted for more than 30 days.

F. Termination of waiver services.

1. In a nonemergency situation, i.e., when the health and safety of the individual or provider personnel is not endangered, the participating provider shall give the individual or family/caregiver, or both, at least 30 days' written notification plus three days for mailing of the intent to discontinue services. The notification letter shall provide the reasons for and the effective date the provider is discontinuing services.

2. In an emergency situation when the health and safety of the individual or provider personnel is endangered, the participating provider must notify DMAS immediately

prior to discontinuing services. The written notification period shall not be required. If appropriate, local DSS Adult Protective Services must also be notified immediately.

12 VAC 30-120-1640. Participation standards for provision of services.

A. Facilities must have a provider agreement approved by DMAS to provide AAL Waiver services.

B. The facility must provide a safe, secure environment for waiver recipients. There may be one or more self-contained special care units in a facility or the whole facility may be a special care unit. Personalized care must be furnished to individuals who reside in their own living units, with semi-private rooms limited to two people and a maximum of two individuals sharing a bathroom.

C. Care in a facility must be furnished in a way that fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible and treat each person with dignity and respect.

D. The medical care of residents must be under the direction and supervision of a licensed physician. This can be the individual's private physician. The facility must ensure that residents have appointments with their physicians at least annually and as needed as determined by the physician.

E. Administrators.

1. Administrators of participating assisted living facilities must meet the regulatory requirements as set forth by the Department of Social Services (22 VAC 40-71-60 et seq.) and the Board of Long-Term Care Administrators (18 VAC 95-20-10 through 18 VAC 95-20-471).

2. The administrator shall demonstrate knowledge, skills and abilities in the administration and management of an assisted living facility program including:

a. Knowledge and understanding of impaired elderly or persons with disabilities;

b. Supervisory and interpersonal skills;

c. Ability to plan and implement the program; and

d. Knowledge of financial management sufficient to ensure program development and continuity.

3. The administrator shall demonstrate knowledge of supervisory and motivational techniques sufficient to:

a. Accomplish day-to-day work;

b. Train, support and develop staff; and

c. Plan responsibilities for staff to ensure that services are provided to participants.

4. The administrator shall complete 20 hours of continuing education annually to maintain and develop skills. This training shall be in addition to first aid, CPR, or orientation training.

F. Nursing staff requirements.

1. Each facility shall have at least one registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, awake, on duty, and on-site in the facility for at least eight hours a day, five days each week and on call 24 hours a day. The person on call must be able to arrive at the facility within one hour.

2. The RN is responsible for staff training, resident assessment, plans of care, and medication oversight.

3. Assessments.

a. Comprehensive assessment. An RN must complete a comprehensive assessment of each resident upon admission. The comprehensive assessment includes the UAI and other relevant social, psychological, and medical information. The comprehensive assessment must also include the physician's assessment information as contained in 22 VAC 40-71-150 L. The comprehensive assessment must be updated yearly and when a significant change in health status or behavior occurs. The information gathered during the comprehensive assessment is used to create the resident's plan of care as contained in 22 VAC 40-71-170 C and D.

b. Plan of care. Based on the individual resident assessment and the UAI, the RN, in coordination with other caregivers including the resident's authorized representative shall:

(1) Develop the resident's plan of care and formulate interventions to address the specific problems identified;

(2) Evaluate both the facility's implementation and the resident's response to the plan of care; and

(3) Review and update the plan of care at least quarterly and more often when necessary to meet the needs of the resident.

c. Monthly assessments. The RN or an LPN under the supervision of the RN must complete a monthly assessment. Significant changes documented on the monthly assessment must be addressed in an updated plan of care. The comprehensive assessment information shall also be updated as needed. At a minimum, the monthly assessment contains the following elements:

(1) Weight loss;

(2) Falls;

(3) Elopements;

(4) Behavioral symptoms;

(5) Adverse reactions to prescribed medications;

(6) Dehydration;

(7) Pressure ulcers;

(8) Fecal impaction;

(9) Cognitive changes;

(10) Change in diagnoses; and

(11) Change in levels of dependence in ADLs[~~;~~ .]

4. In a facility with fewer than 16 waiver recipients, the facility may employ an RN as part time or as a contracted employee.

The facility's RN may also serve as the administrator. In all instances where the facility's RN is assigned duties as an administrator, the facility shall assure that the RN devotes sufficient time and effort to all clinical duties to secure health, safety, and welfare of recipients.

Any facility having more than 16 waiver recipients must employ full time an RN to be responsible for the clinical needs of the recipients.

G. Unit coordinator.

1. Facilities must have a unit coordinator, awake and on-site in the unit, who will manage the daily routine operation of the specialty unit.

2. The unit coordinator must be available to the facility 24 hours a day.

3. At a minimum, the unit coordinator must be a certified nurse aide (CNA) with at least one year experience in a DMAS-approved assisted living facility or nursing home or other setting that involves working with vulnerable adults.

4. The unit coordinator may be an RN or an LPN who is serving as the assisted living facility's daily nurse, the administrator, or the activities director.

5. In the event the unit coordinator is not available, an alternate qualified staff member may serve in this capacity. Each assisted living facility must establish its own written protocol and assure that only qualified staff fulfills this requirement.

6. In all instances where the facility's RN is assigned other duties as an administrator, unit coordinator, or both, the facility must assure that the RN devotes sufficient time and effort to all clinical duties.

H. Structured activities program. There shall be a designated employee responsible for managing or coordinating the structured activities program. This employee shall be on site in the special care unit at least 20 hours a week, shall maintain personal interaction with the residents and familiarity with their needs and interests, and shall meet at least one of the following qualifications:

1. Be a qualified therapeutic recreation specialist or activities professional;

2. Be eligible for certification as a therapeutic recreation specialist or an activities professional by a recognized accrediting body;

3. Have at least one year full-time work experience within the last five years in an activities program in an adult care setting;

4. Be a qualified occupational therapist or an occupational therapy assistant; or

5. Prior to or within six months of employment, have successfully completed 40 hours of VDSS-approved training.

I. Certified nurse aides. In order to provide services in this waiver, the assisted living facility must use certified nurse aides (CNA) in the specialty unit at all times.

J. The assisted living facility must have sufficient qualified and trained staff to meet the needs of the residents at all times.

K. There must be at least two awake direct care staff in the special care unit at all times and more if dictated by the needs of the residents.

L. Training requirements for all staff.

1. All staff who have contact with residents, including the administrator, shall have completed 12 hours of dementia-specific training within 30 days of employment. The training must be conducted by a health care educator, adult education professional, or a licensed professional, with expertise in dementia. The health care educator, adult education professional, or licensed professional must be acting within the scope of the requirements of his profession and have had at least 12 hours of training in the care of individuals with cognitive impairments due to dementia prior to performing the training.

2. All direct care staff must receive annual training in accordance with 22 VAC 40-71-630, with at least eight hours of training in the care of residents with dementia and medical nursing needs. This training may be incorporated into the existing training program and must address the medical nursing needs specific to each resident in the special care unit. This training must also incorporate problem areas that may include weight loss, falls, elopements, behavioral symptoms, and adverse reactions to prescribed medications. A health care educator, adult education professional or licensed professional with expertise in dementia must conduct this training. The health care educator, adult education professional or licensed professional must be acting within

the scope of his profession and have had at least 12 hours of training in the care of individuals with cognitive impairments due to dementia prior to performing the training.

3. The individual conducting the training must have at least three years of experience in the health care or dementia care field. In addition to health care educators and adult education professionals, licensed professionals eligible to conduct the training include: physicians, psychologists, registered nurses, occupational therapists, physical therapists, speech/language pathologists, licensed clinical social workers, and licensed professional counselors.

M. Documentation. The assisted living facility shall maintain the following documentation for review by DMAS staff for each assisted living resident:

1. All UAIs, authorization forms, plans of care and assessments completed for the resident maintained for a period not less than six years from the recipient's start of care in that facility;

2. All written communication related to the provision of care between the facility and the assessor, licensed health care professional, DMAS, VDSS, the recipient, or other related parties; and

3. A log that documents each day that the recipient is present in the facility.

12 VAC 30-120-1650. Payment for services.

A. DMAS shall pay the facility a per diem fee for each AAL Waiver recipient authorized to receive assisted living services. Except for 14 days of leave each calendar year as

described in subsection C of this section, payment of the per diem fee is limited to the days in which the recipient is physically present in the facility.

B. The services that are provided as a part of the auxiliary grant rate pursuant to 22 VAC 40-25 will not be included for payment from the waiver.

C. Periods of absence from the assisted living facility.

1. An assisted living facility AAL Waiver bed may be held for leave when the resident's plan of care provides for such leave. Leave includes visits with relatives and friends or admission to a rehabilitation center for up to seven days for an evaluation. Leave does not include periods of absence due to an admission to a hospital or nursing facility.

2. Leave is limited to 14 days in any 12-month period. Leave is resident specific and is counted from the first occurrence of overnight leave that a resident takes. From that date, a resident has 14 days of leave available during the next 365 days.

3. After the 14 days of leave have been exhausted and during periods of absence due to a hospital or nursing facility admission, the assisted living facility may choose to hold the bed for the resident, but DMAS will not pay for the service. The resident or the resident's authorized representative may choose to pay to hold the bed by paying the assisted living facility directly using other funds. The rate shall be negotiated between the resident's authorized representative and the assisted living facility, but shall not exceed the auxiliary grant rate in effect at the time of the resident's absence.

4. During periods of absence for any reason, DMAS shall hold the waiver slot for the resident for a total of 30 consecutive days. If the resident's absence exceeds 30 days, DMAS shall terminate AAL Waiver services and assign the slot to the next person on the waiting list.

12 VAC 30-120-1660. Utilization review.

A. DMAS shall conduct audits of the services billed to DMAS and interview recipients to ensure that services are being provided and billed in accordance with DMAS policies and procedures.

B. DMAS will review all facilities providing services in this waiver on a regular basis. All quality management and level of care reviews will be performed at least annually and will be performed on site.

CERTIFIED: I hereby certify that these regulations are full, true and correctly dated.

__________________ ______________________________
Date Patrick W. Finnerty, Director
Dept of Medical Assistance Services