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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING AGENCY-DIRECTED PERSONAL/RESPITE CARE PROVIDER

A participating personal/respice care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS (see the DMAS website, Provider Services, at the following address: <http://www.dmas.virginia.gov/pr-home.htm> for a sample of this form). The duties and responsibilities of the provider are the same for both services. Each service requires a separate Participation Agreement and provider identification (ID) number. The term “personal/respice care” is used throughout this manual wherever procedures and policies are alike for both services. A provider may, however, choose to offer only one of the two services.

Personal/respice care providers provide services designed to prevent or reduce institutional care by providing eligible recipients with personal care aides who perform basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of personal/respice care as a part of the Elderly or Disabled with Consumer-Direction (EDCD) Waiver. The personal/respice care provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

PARTICIPATING RESPITE FACILITY PROVIDER

A participating respite facility provider is a Medicaid-enrolled nursing facility.

PARTICIPATING ADULT DAY HEALTH CARE (ADHC) PROVIDER

A participating Adult Day Health Care (ADHC) provider is a facility that is licensed by the Virginia Department of Social Services (DSS) as an adult day care center, meets the standards and requirements set forth by DMAS, and has a current, signed Participation Agreement with DMAS (see the DMAS website, Provider Services, at the following address: <http://www.dmas.virginia.gov/pr-home.htm>) for a sample of this form).

ADHCs offer community-based day programs providing a variety of health, therapeutic, and social services designed to meet the specialized needs of elderly and physically disabled recipients who are at risk of being placed in a nursing facility. ADHC services enable recipients to remain in their communities and to function at the highest level possible by augmenting the social support system already available to the recipient, rather than replacing the support system with more expensive institutional care. The ADHC is reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this provider manual.

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PARTICIPATING PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) AND MEDICATION MONITORING PROVIDER

A participating Personal Emergency Response System (PERS) and Medication Monitoring provider is a certified home health or personal care agency, a Durable Medical Equipment (DME) provider, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring. The PERS provider must meet the standards and requirements set forth by DMAS, and have a current, signed Participation Agreement with DMAS (see the DMAS website, Provider Services, at the following address: <http://www.dmas.virginia.gov/pr-home.htm> for a sample of this form). All PERS providers must enroll as DME providers in order to provide this service to Medicaid recipients and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

PERS and Medication Monitoring services are designed to prevent or reduce inappropriate institutional care by providing eligible recipients with services that will allow them to live independently while having access to emergency services. This chapter specifies the requirements for approval to participate as a Medicaid provider of the PERS and Medication Monitoring services as a part of the EDCD Waiver. The provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

PARTICIPATING SERVICE FACILITATION PROVIDER

A participating Consumer-Directed (CD) Service Facilitator (SF) is a facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed Participation Agreement with DMAS.

Service facilitation agencies provide supportive services designed to prevent or reduce inappropriate institutional care by offering assistance to eligible recipients for the hiring, training, supervising, and firing responsibilities of the personal care aides, who perform basic health-related services. This chapter specifies the requirements for approval to participate as a Medicaid provider of service facilitation services. The service facilitation provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid program prior to billing for any services provided to Medicaid clients. A copy of the Provider Agreement can be found in this chapter. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment/Certification Unit. An original signature of the individual provider is required.

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Upon receipt of the above information, a Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

A copy of the Provider Agreement, with instructions on how to complete the forms, can be found at the DMAS website, www.dmas.virginia.gov, or by contacting the Provider Enrollment/Certification Unit toll-free at 1-888-829-5373. All providers must sign, complete the entire application, and submit it to the Provider Enrollment/Certification Unit. An original signature of the individual provider is required. The Medicaid Participation Agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement with the Provider Enrollment/Certification Unit as a result of any name change or change of ownership.

Providers may request Participation Agreements by writing, calling, or faxing a request to:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, VA 23261-6803

Phone: 1-804-270-5105 or 1-888-829-5373 (toll-free, in-state only)
Fax: 1-804-270-7027

AREAS OF SERVICE

The provider applicant notes on the application what localities (cities and counties) the provider wishes to serve. The provider must be able to adequately staff and supervise staff in any locality served by the provider's office. The provider may maintain separate provider agencies.

The provider should submit a provider application for each separate office which, upon approval, will be issued a separate provider identification number and will be expected to maintain all files related to individuals served by the office and to bill for those individuals from the office.

A differential rate is established for providers that are providing services to individuals residing in the Northern Virginia localities to reflect the higher cost of operating in these localities (both higher capital and wage costs).

PROVIDER MAILINGS

Providers may choose to have their payments sent to one location and their other mailings, such as memorandums or letters, sent to another location within their organization. Please visit the DMAS website or contact the First Health – Provider Enrollment Unit (FH-PEU) if this is an option you would like to explore.

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PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. Currently, dissemination of this information is accomplished through the DMAS website as well as, with regard to certain publications, by mailing such publications directly to providers, keyed to the provider number on the enrollment file. For publications that are mailed to providers, this means that each assigned provider receives program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of such publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the First Health - Provider Enrollment Unit at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that program information not be sent. The address is:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, Virginia 23261-6803

Phone: 1-804-270-5105 or 1-888-829-5373 (toll-free, in-state only)
Fax: 1-804-270-7027

To resume the mailings, a written request must be sent to the address above.

Copies of manuals, manual updates, and certain other publications are available on the DMAS website (www.dmas.virginia.gov). If you do not have access to the Internet, please contact DMAS' mailing contractor, Commonwealth Martin, at 804-780-0076.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid program must adhere to the conditions of participation outlined in their Participation Agreements and must perform the following activities as well as any other specified by DMAS:

- Immediately notify DMAS and the First Health - Provider Enrollment Unit (FH-PEU), in writing, of any change in the information that the provider previously submitted to DMAS or FH-PEU. This includes any change in provider status (location, mailing and payment address, etc);
- Assure freedom of choice to recipients seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and included in the recipient's Plan of Care and participating in the Medicaid program at the time the service or services were performed;
- Assure the recipient's freedom to reject medical care and treatment;

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- Accept referrals for services only when staff is available to initiate and perform the services on an ongoing basis;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which states that no otherwise qualified recipient with a disability shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Rehabilitation Act of 1973, as amended, requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to recipients in full compliance with Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.), as amended, which provides civil rights protections to persons with disabilities with respect to employment, public accommodations, state and local government services, and telecommunications;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;
- Submit charges to DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party;
- Accept Medicaid payment from the first day of eligibility;
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR, Section 447.15, provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered;

Example: If a third party payer reimburses \$5 out of an \$8 charge and Medicaid's allowance is \$5, then payment in full of the Medicaid allowance has been made;

- Providers cannot bill recipients or DMAS for broken or missed appointments;
- Accept assignment of Medicare benefits for eligible Medicaid recipients;

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- Use program-designated billing forms for submission of charges;
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all provider business is conducted;
- Such records must be retained for a period of not less than six years from the last date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years;
- Policies regarding the retention of records shall apply even if the provider discontinues operation. DMAS must be notified in writing of the storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee should be within the Commonwealth of Virginia;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- 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 Medicaid recipients;
- When ownership of the provider agency changes, DMAS shall be notified at least 15 calendar days before the date of the change;
- Hold confidential and use only for authorized DMAS purposes all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public;
- Employ and supervise professionally trained staff meeting the requirements stated in this chapter; and
- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in any state or federal court and agree to inform DMAS of any action instituted with respect to financial solvency.

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BUSINESS OFFICE

The provider must operate from a business office, which is staffed and provides accessible staff space, files, business telephones for the recipient to contact the provider when necessary, and an address for receipt of mail and forms.

RECIPIENT CHOICE OF PROVIDER

If services are authorized and there is more than one approved provider in the community, the recipient will have the option of selecting the provider of his or her choice.

At the time individuals are approved for services, the Pre-Admission Screening (PAS) Team must inform the individual of available service providers and (1) that they have the option of selecting their providers and (2) provide a list of service providers from which to choose.

ADVANCE DIRECTIVES

At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult recipients with written information regarding each individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the recipient is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require recipients to execute an advance directive.

Under the law, providers must:

- Provide all adult recipients with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;
- Inform recipients about the provider's policy on implementing advance directives;
- Document in the recipient's medical record whether he or she has signed an advance directive;
- Not discriminate against a recipient based on whether he or she has executed an advance directive; and
- Provide staff and community education on advance directives.

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PROVIDER PARTICIPATION STANDARDS FOR PERSONAL/RESPIRE CARE SERVICES

In addition to the above, to be enrolled as a Medicaid personal/respite care provider and maintain provider status, an agency must meet the following special participation conditions:

Staffing Requirements

1. Registered Nurse (RN)

The provider must employ (or subcontract) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all personal care aides. The RN must be able to practice in the Commonwealth of Virginia and have at least two (2) years of related clinical experience as a RN or a licensed practical nurse (LPN). Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility. The RN must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children, recorded in the nurse's personnel file. Also, the provider must comply with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks. Documentation of license, clinical experience, work references, and evidence of a criminal background record check must be maintained in the RN's personnel file for review by DMAS staff.

2. Personal Care Aide

Each personal care aide hired by the provider must be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Basic qualifications for personal care aides include:

- Physical ability to do the work;
- 18 years or older;
- Ability to read and write in English to the degree necessary to perform the expected tasks and possess basic math skills;
- Completion of DMAS-approved nurse aide training program. A list of approved schools and programs are located on the DMAS website at www.dmas.virginia.gov. Prior to assigning an aide to a recipient, the provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. If the aide training program/school is not listed on the approved list, the provider can submit a copy of the aide certificate and the school's curriculum to the Waiver Services Unit (WSU) at DMAS for verification of the aide's qualifications to provide Medicaid services under the EDCD Waiver. (see the DMAS website, Provider Services, at the following address: <http://www.dmas.virginia.gov/pr-home.htm> for a sample of this form);

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DMAS requirements may be met in one of three ways:

- a. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration containing a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as a personal care aide. A copy of the state certificate must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the agency must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons and that the aide meets one of the other two DMAS requirements. DMAS does not require a Board of Nursing Nurse Aide Certification to perform personal/respite care services; it is merely one type of certification that meets DMAS requirements.
- b. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which offer certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of these Board of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, ensure that it is from a Board of Nursing-accredited institution, and maintain this documentation in the aide's personnel file for review by DMAS staff.

Numerous hospitals, nursing facilities, and educational institutions also provide nursing assistant training that is not Board of Nursing-approved (e.g., out-of-state curricula). To ensure that the training content for a Nursing Assistant Program not approved by the Board of Nursing meets the minimum acceptable requirements, the agency must contact the DMAS Waiver Services Unit to determine whether the curriculum has previously been approved by DMAS. If the curriculum was not previously approved by DMAS, the provider must obtain the curriculum and submit it to DMAS for approval prior to offering employment for Medicaid-reimbursed cases.

- c. Provider-Offered Training: In lieu of participating in a course offered at an educational institution, a provider may develop and offer its own training program or use the DMAS Personal Care Aide Training Curriculum (see the DMAS website, Provider Services, at the following address: <http://www.dmas.virginia.gov/pr-home.htm> for a sample of this form). The content of the training must be consistent with the DMAS Personal Care Aide Training curriculum. The curriculum must be approved by DMAS prior to offering this training.

ALL graduates from an approved DMAS 40 hour provider training program must have a certificate of completion with the RN instructor's signature, printed name, and date of course completion. Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to a recipient. Based on continuing evaluations of the aide's performance and the recipient's

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individual needs, the RN Supervisor shall identify any significant gaps in the aide's ability to function competently and shall provide the necessary training.

The provider should verify all information on the employment application prior to hiring a personal care aide. The aide must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. If possible, obtain references from the educational facility, vocational school, or institution where the aide's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff. Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks. The provider must have documentation proving that a criminal background check was obtained and that the employee is in compliance with § 32.1-162.9:1. This documentation must be made available to DMAS staff upon request. In addition, the provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the *Code of Virginia*.

A personal care cannot be the parents/stepparents of minor children or spouses of recipients receiving waiver services. Payment may be made for services rendered by other family members only when there is written, objective documentation as to why no other aide is able to render services to that individual. For agency-directed services, the family member providing care to the recipient must be employed by the personal care provider and must meet the same requirements as other aides.

It is extremely important that the minimum qualifications be met by each personal care aide to ensure the health, safety, and welfare of each recipient enrolled in the EDCD Waiver.

3. Licensed Practical Nurse (LPN)

Through the respite care program, the provider may be reimbursed for the services of a LPN currently able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual's skilled needs. DMAS will reimburse for LPN respite care for those recipients who require the skilled level of care and who meet the criteria below.

The circumstances that warrant provision of respite care by a LPN are:

- The recipient receiving care has a need for routine skilled care that cannot be provided by unlicensed personnel (i.e., recipient on a ventilator, recipient requiring nasogastric or gastrostomy feedings, etc.);
- No other individual in the recipient's support system is able to provide the skilled component of the individual's care during the caregiver's absence;

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- The recipient is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver; and
- A physician's order for services is obtained prior to the service begin date and updated every six months.

The provider must verify a satisfactory work record of the LPN providing respite care through at least two (2) references obtained from prior employment, 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 provider must have documentation proving that a criminal background check was obtained and that the employee is in compliance with § 32.1-162.9:1. This documentation must be made available to DMAS staff upon request. If possible, obtain references from the educational facility, vocational school, or institution where the LPN received training. Documentation of the date of the reference check, the individual contacted and their relationship to the LPN (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record. The provider shall not hire any persons who have been convicted of barrier crimes in § 32.1-162.9:1 of the *Code of Virginia*.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS staff.

Change of Ownership

When ownership of the provider changes, DMAS and FHS-PEU must be notified within 15 calendar days from the effective date of the change. A new Participation Agreement with a notice of organizational structure, statements of financial solvency and service comparability, and full disclosure of all information required by this chapter relating to ownership and interest will be required.

In addition to the above, all providers enrolled in the Virginia Medicaid program must adhere to the conditions outlined in their individual Participation Agreements.

PROVIDER PARTICIPATION STANDARDS FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

Licensing Requirement

To be enrolled as a Medicaid Adult Day Health Care (ADHC) provider, the ADHC Center must be an Adult Day Care Center licensed by the Virginia Department of Social Services (DSS). A copy of the current license must be available to FHS-PEU for verification purposes prior to enrollment as a Medicaid provider. DMAS will notify DSS when an ADHC agreement is issued to a licensed center. DSS will notify DMAS whenever a change to the ADHC's status as a licensed Adult Day Care Center is made by DSS.

Each ADHC Center participating with Medicaid is responsible for adhering to the DSS Adult Day Care Center standards. The DMAS special participation conditions included here are

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standards imposed in addition to DSS standards, which must be met to perform Medicaid ADHC services.

Physical Plant Requirements

The ADHC must be able to provide a separate room or area, equipped with one bed or cot for every twelve Medicaid recipients. This bed or cot must be available for anyone who becomes ill, needs to rest, or needs to have privacy.

Staff Requirements

The number of staff required for an ADHC Center depends upon the level of care required by its participants. Each ADHC Center is required to employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each recipient. The following staffing guidelines are required by DMAS. However, DMAS reserves the right to require an ADHC Center to employ additional staff, if, on review, DMAS staff find evidence of unmet recipient needs.

“Staff” is defined as professional and aide staff.

“Professional staff” is defined as the Director, Activities Director, RN, Therapist, or Social Worker.

Adult Day Health Care (ADHC) Minimum Staffing Requirements

1. The ADHC Center will always maintain a minimum staff-recipient ratio of one staff member to every six recipients (Medicaid and other participants).
2. There shall be at least two (2) staff persons at the ADHC Center at all times when there are Medicaid recipients in attendance.
3. In the absence of the Director, a professional staff member shall be designated to supervise the program.
4. Volunteers shall be included in the staff-recipient ratio only when they meet the qualifications and training requirements of paid staff, and, for each volunteer, there shall be at least one paid employee also included in the staff-recipient ratio.
5. Any ADHC Center that is co-located with another facility shall count only its own separate identifiable staff in the Center’s staff-recipient ratio.
6. The ADHC Center must employ staff sufficient to meet the needs of the recipients.

These staff are the:

- Director - responsible for the overall management of the ADHC Center’s programs. This individual is the provider contact person for the preauthorization contractor and is responsible for participation agreements and

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receiving and responding to communication from DMAS. The Director is responsible for ensuring the initial development of the Plan of Care (DMAS-301) for ADHC recipients;

- Activities Director - responsible for directing recreational and social activities for the ADHC recipients;
- Program Aides - responsible for overall assistance with care and maintenance of the recipient (assistance with activities of daily living, recreational activities, and other health and therapeutic related activities); and
- Registered Nurse (RN) - responsible for administering and monitoring the health needs of the ADHC recipients. The RN is responsible for the planning, organization, and management of a Plan of Care involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. The RN must be present a minimum of 8 hours each month at the ADHC Center. The nurse must be available to meet the nursing needs of all Medicaid ADHC recipients. DMAS does not require that the nurse be a full-time staff position, but the nurse's schedule must be arranged so that each recipient is seen every month. There must be a RN available, by telephone at a minimum, to the ADHC Center's recipients during all times the ADHC Center is in operation. The ADHC Center may contract with either an individual or agency to provide these services, but the ADHC Center must ensure quality service delivery and coordination of the Plan of Care.

The ADHC Center may use one person to fill more than one professional position as long as the requirements for both positions and other staffing requirements are met. The ADHC Center may employ staff as either full-time or part-time as long as the person hired can fulfill the duties of the position and meet the needs of the recipients. DMAS will enter into Participation Agreements only with ADHC Centers employing a sufficient number of staff whose employment status (full-time, part-time, or contracted RN services) is determined to be sufficient based on the number of recipients in the ADHC Center and the overall functional level or specialized needs of those recipients.

7. The Director will assign a professional staff member to act as ADHC Coordinator for each recipient. The identity of the ADHC Coordinator must be documented in the recipient's file. The ADHC Coordinator is responsible for management of the recipient's Plan of Care and review of the recipient's Plan of Care with the program aides. In cases where the recipient only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.
8. All staff must be 18 years of age or older.

It is the ADHC Coordinator's responsibility to inform the program aides of changes in the Plan of Care and give instruction and direct supervision in any new tasks. If the recipient's Plan of Care requires a particular task a program aide is not familiar with, any professional staff available is expected to provide the aide with instruction and direct supervision in the task.

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Each professional staff member is responsible for providing input to the Plan of Care, sharing expertise with other staff members through in-services, providing direct supervision to aides or providing direct care to the recipients, or both.

A multi-disciplinary approach to problem identification, recipient goal setting, development and implementation of the Plan of Care and supervision of nonprofessional staff is essential to ensure the provision of quality ADHC services. However, the Center Director has the ultimate responsibility for directing the ADHC Center program and supervision of its staff.

Minimum Qualifications of Adult Day Health Care Staff

I. Program Aide

Each program aide hired by the provider must be evaluated by the provider to ensure compliance with minimum qualifications as required by DMAS. Basic qualifications for ADHC program aides include:

- Ability to read and write in English to the degree necessary to perform the expected tasks;
- Physically able to do the work; and
- Special training in the needs of the elderly and individuals with disabilities through the completion of a minimum 40-hour training program consistent with DMAS requirements. The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. See the DMAS website, at the following address: http://www.dmas.virginia.gov/downloads/pdfs/ltc-Complete_PCA_Curriculum_020103.pdf for a copy of the training curriculum.
- DMAS requirements may be met in one of five ways:
 1. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration, which contains a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as an ADHC Aide. A copy of the state certification must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the provider must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons. DMAS does not require Board of Nursing Nurse Aide Certification in order to perform ADHC aide services; it is merely one type of certification that meets DMAS requirements.
 2. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which award certificates qualifying the graduate as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of the Board

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of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, verify that it is from a Board of Nursing-accredited institution, and maintain the documentation in the aide's personnel file for review by DMAS staff.

Nursing Assistant training is also provided by numerous hospitals, nursing facilities, and educational institutions, which are not approved by the Board of Nursing (e.g., out-of-state curricula). To ensure that the training content for a Nursing Assistant Program not approved by the Board of Nursing meets the minimum acceptable requirements, the agency must contact the DMAS Waiver Services Unit at 804-786-1465 to determine whether the curriculum has previously been approved by DMAS. If the curriculum was not previously approved by DMAS, the provider must obtain the curriculum and submit it to DMAS for approval prior to offering employment for Medicaid reimbursed cases.

3. Provider-Offered Training: An aide that has completed the aide training for in-home personal/respite care services approved by DMAS meet the requirements for working in an ADHC.
4. Completion of the VADSA (Virginia Adult Day Services Association) Aide Training program is acceptable. This program has been previously reviewed and approved by DMAS. Note: an aide who has completed the VADSA training does not meet the qualifications as an aide for in-home personal/respite care services.
5. Completion of the most current National Adult Day Services Association curriculum. (Information for this curriculum can be accessed by mailing a request in writing to the address below or by checking their website at www.ncoa.org):

The National Adult Day Health Services Association
409 Third Street, SW
Suite 200
Washington, DC 20024

Note: An aide who has completed this training does not meet the qualifications as an aide for in-home personal/respite care services.

The aide must have a satisfactory work history as evidenced by two (2) satisfactory reference checks 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 provider must have documentation proving that a criminal background check was obtained and that the employee is in compliance with § 32.1-162.9:1. This documentation must be made available to DMAS staff upon request. If possible, obtain references from the educational facility, vocational school, or institution where the aide's training was received. Documentation of the

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date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff. In addition, the provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the *Code of Virginia*.

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to ADHC recipients. The provider must verify all information on the employment application prior to hiring an ADHC program aide. It is important that the minimum qualifications be met by each hired aide to ensure the health and safety of recipients.

II. Registered Nurse (RN)

The RN must:

- A. Be registered and currently licensed to practice nursing in the Commonwealth of Virginia;
- B. Have two years of related clinical experience as an RN. Clinical experience may include work in an acute care hospital, rehabilitation hospital, public health clinic, home health agency, or nursing facility; and
- C. The RN must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children, recorded in the nurse's personnel file. Also, the provider must comply with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks. Documentation of both license and clinical experience must be maintained in the provider's personnel file for review by DMAS staff. A copy of the RN's current license must be in the personnel record.

III. Activity Director

The Activity Director must:

- A. Have a minimum of 48 semester hours or 72 quarter hours of post-secondary education from an accredited college or university with a degree in recreational therapy, occupational therapy, or a related field such as art, music, or physical education;
- B. Have one year of related experience, which may include work in an acute care hospital, rehabilitation hospital, nursing home, or have completed a course of study including the prescribed internship in occupational, physical, and recreational therapy or music, dance, art therapy, or physical education; and

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- C. Have a satisfactory work record as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks. The provider must have documentation proving that a criminal background check was obtained and that the employee is in compliance with § 32.1-162.9:1. This documentation must be made available to DMAS staff upon request.

IV. Director

The Director must meet the qualifications of the Director as specified in the DSS standards for Adult Day Care Centers.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS staff.

PROVIDER PARTICIPATION STANDARDS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) AND MEDICATION MONITORING SYSTEMS

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, PERS providers, which provide PERS and Medication Monitoring, must also meet the qualifications described below.

To be enrolled as a provider of PERS, a provider must be a certified home health or personal care agency, a Durable Medical Equipment (DME) provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring. All PERS providers must enroll as a DME provider in order to provide this service to Medicaid recipients and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services.

The PERS provider must provide an emergency response center staff with fully trained operators who are capable of receiving signals for help from a recipient's PERS equipment 24 hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS recipient needs emergency help.

The PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the recipient's notification of a malfunction of the console unit or activating devices, while the original equipment is being repaired.

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The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

The PERS installation includes local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the telephone be off the hook or in use when the unit is activated.

The PERS provider must maintain all installed PERS equipment in proper working order.

The PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS. The record must document all of the following: delivery date and installation date of the PERS; enrollee/caregiver signature verifying receipt of the PERS device; verification by a test that the PERS device is operational, monthly or more frequently as needed; updated and current recipient responder and contact information, as provided by the recipient or the recipient's care provider; and a case log documenting recipient system utilization and recipient or responder contacts and communications.

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

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) Safety Standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL Safety Standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

The PERS provider must furnish education, data, and ongoing assistance to DMAS to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the recipient, caregiver, and responders in the use of the PERS service.

The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the recipient's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the recipient resetting the system in the event it cannot get its signal accepted at the response center.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from the recipient's PERS equipment. The monitoring agency's equipment must include the following: a primary receiver and a back-up receiver,

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which must be independent and interchangeable; a back-up information retrieval system; a clock printer, which must print out the time and date of the emergency signal, the PERS recipient's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test; a back-up power supply; a separate telephone service; a toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and a telephone-line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

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

The PERS provider shall document and furnish a written report for each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or activations made in error. This written report shall be furnished to the personal care provider or, in cases where the recipient only receives ADHC services, to the ADHC provider.

The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid recipients. "Direct marketing" means directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; mailing directly; paying "finder's fees"; offering financial incentives, rewards, gifts, or special opportunities to eligible recipients as inducements to use their services; continuous, periodic marketing activities to the same prospective recipient (e.g., monthly, quarterly, or annual give-aways) as inducements to use their services; or engaging in marketing activities that offer potential customer rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing recipients' use of providers' services.

In addition to the above, all PERS providers enrolled in the Virginia Medicaid program must adhere to the conditions outlined in their individual Participation Agreements.

PROVIDER PARTICIPATION STANDARDS FOR CONSUMER-DIRECTED (CD) SERVICES

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, CD service providers must meet the following special participation conditions:

1. CD Service Facilitator Requirements

The CD Service Facilitator (SF) provides ongoing supervision of the individual's Service Plan. It is preferred that the CD Service Facilitator possess a minimum of an undergraduate degree in a human services field or be a RN currently licensed to practice in the Commonwealth of Virginia. The Service Facilitator must be 18 years of age or older. In addition, the CD Service Facilitator must have two years of satisfactory experience in the human services field working with persons with severe disabilities or the elderly. The CD Service 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

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documented on the application form, found in supporting documentation, or observed during the interview. Observations during the interview must be documented. The knowledge, skills, and abilities shall include, but are not necessarily limited to:

a. Knowledge of:

- (1) Types of functional limitations and health problems that are common to different disability types and the aging process, as well as strategies to reduce limitations and health problems;
- (2) Physical assistance typically required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
- (3) Equipment and environmental modifications that are commonly used and required by people with physical disabilities or elderly persons, which reduce the need for human help and improve safety;
- (4) Various long-term care program requirements, including nursing home and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance and respite services;
- (5) DMAS consumer-directed personal care aide and respite services program requirements, as well as the administrative duties for which the individual will be responsible;
- (6) Conducting assessments (including environmental, psychosocial, and functional factors) and their uses in care planning;
- (7) Interviewing techniques;
- (8) The recipient's right to make decisions about, direct the provisions of, and control his or her services, including hiring, training, managing, approving time sheets, and firing a personal care aide;
- (9) The principles of human behavior and interpersonal relationships; and
- (10) General principles of record documentation.

b. Skills in:

- (1) Negotiating with individuals and service providers;
- (2) Observing, recording, and reporting behaviors;

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(3) Identifying, developing, and providing services to persons with severe disabilities or elderly persons; and

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

c. Ability to:

(1) Report findings of the assessment or onsite visit, either in writing or in an alternative format for persons who have print 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 both orally and in writing; and

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

Documentation of a degree or license and previous satisfactory experience must be maintained in the provider's personnel file for review by DMAS staff. There must also be documentation of positive work history as evidenced by at least two satisfactory reference checks recorded in the CD Service Facilitator's personnel file.

If the CD Service Facilitator is not a RN, the CD Service Facilitator must inform the individual's primary health care provider that services are being provided and request consultation as needed. A lapse in qualified CD Service Facilitator availability may require that the CD Service Facilitator subcontract with another provider until appropriate staff can be hired. If the provider is unable to provide service facilitation services for a period of 30 days, the CD Service Facilitator should transfer recipients to another CD SF and immediately notify the prior-authorization contractor.

The inability to obtain and retain personal care aides can be a serious threat to the safety and health of a recipient. If a recipient is consistently (over a 30-day period) unable to hire and retain the employment of a personal care aide, the CD SF should discuss transferring the recipient to agency-directed (AD) services.

2. Consumer-Directed (CD) Personal Care Attendant Requirements

It is the recipient's responsibility to hire, train, supervise, and, if necessary, fire the personal care aide. Each personal care aide hired by the recipient must be evaluated by the recipient to ensure compliance with the minimum qualifications as required by DMAS. Basic qualifications for personal care aides include:

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- Being 18 years of age or older;
- Being able to read and write in English to the degree necessary to perform the tasks expected;
- Possessing basic math, reading, and writing skills;
- Having the required skills to perform care as specified in the individual's Plan of Care;
- Possessing a valid Social Security Number;
- Submitting to a criminal history record check and a child protective services central registry check for care aides that care for minor children. The personal care aide will not be compensated for services provided to the individual once the records check verifies the personal care aide has been convicted of any of the crimes that are described in 12 VAC 30-90-180;
- the individual once the records check verifies the personal care aide has been convicted of any of the crimes that are described in 12 VAC 30-90-180;
- Willingness to attend or receive training at the recipient's request;
- Understanding and agreeing to comply with the consumer-directed personal/respite services program requirements;
- Receive periodic tuberculosis (TB) screening;
- Personal care aides may be members of the recipient's family, with the exception of parents or stepparents of a minor (under 18 years of age), or a recipient's spouse. In addition, anyone who has legal guardianship for the recipient shall also be prohibited from being a personal care aide under this program. A non-family live-in personal care aide may be the provider of Medicaid-funded consumer-directed personal/respite services for any competent recipient; and
- Personal care aides who are providing direct care to recipients are prohibited from also directing that recipient's consumer-directed services.

The recipient should verify information on the application form prior to hiring a personal care aide. It is important that the minimum qualifications be met by each personal care aide hired to ensure the health and safety of recipients. These qualifications must be documented by the recipient and maintained by the CD SF for review by DMAS staff.

CD Service Facilitators are not responsible for finding personal care aides for the recipient. CD SFs are also not responsible for verifying personal care aides' qualifications. This is the employer's responsibility.

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UTILIZATION REVIEW (UR)

Utilization review is conducted periodically. DMAS Analysts or another DMAS designee will review provider compliance with participation standards during utilization review. DMAS may retract funds based on documentation reviewed. (See Chapter VI for more information about utilization review.)

ANNUAL LEVEL-OF-CARE REVIEWS

DMAS will conduct annual level-of-care reviews of each recipient according to established procedures described in Chapter VI.

RECIPIENT RIGHTS/RESPONSIBILITIES

The provider must have a written statement of recipient rights, which clearly states the responsibilities of both the provider and the recipient in the provision of care. This statement of recipient rights must be signed by the recipient and the provider representative at the time services are initiated. This statement must be maintained in the recipient's file, and a copy must be given to the recipient. The statement of recipient rights must include the following:

- The provider's responsibility to notify the recipient in writing of any action taken which affects the recipient's services;
- The provider's responsibility to render services according to acceptable standards of care;
- The provider's procedures for patient pay collection;
- The recipient's obligation for patient pay, if applicable;
- The provider's responsibility to make a good faith effort to provide care according to the scheduled Plan of Care and to notify the recipient when unable to provide care;
- The provider must inform the recipient of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the recipient should contact regarding schedule changes;
- The provider's responsibility to treat the recipient with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the recipient about his or her satisfaction with the services being rendered;
- Offer the individual choice of provider agencies and waiver services;
- The recipient's responsibility to notify the appropriate provider staff whenever the recipient's schedule changes or assigned staff fail to appear for work; and
- The recipient's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.

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The Recipient's Rights/Responsibilities Statement must include the following notification of the appropriate resources for complaint resolution:

“The DMAS (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services you should contact (RN, Service Facilitator, ADHC Coordinator, Provider Director, or PERS provider) at (provider telephone).”

If the staff at the agency is unable or unwilling to help you resolve the problem, you may contact the Waiver Services Unit at DMAS by calling 804-786-1465 or by mail at:

DMAS
Waiver Services Unit
600 East Broad Street
Suite 1300
Richmond, VA 23219

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for individuals with disabilities in the provider's program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

The Participation Agreement may be time-limited. It will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of any renewed license or certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and to the First Health Provider Enrollment Unit thirty (30) days prior to the effective date. The addresses are as follows:

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Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health VMAP Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261

DMAS may terminate a provider from participating upon 30 days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients after the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection § 32.1-325 (c) of the *Code of Virginia* mandates that any Medicaid agreement or contract shall terminate upon conviction of the provider of a felony. A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

STATE-OPERATED PROVIDER

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based upon utilization or QMR decisions. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

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Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

RECONSIDERATION AND APPEALS OF ADVERSE DECISIONS

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the overpayment and/or denial to the attention of the appropriate Agency Division that issued the adverse action at the following address:

(Insert appropriate Agency Division)
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, the provider may appeal the reconsideration decision. A provider may appeal where a service has already been provided by filing a written notice for a first-level appeal with the DMAS Appeals Division within 30 days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

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Appeals Division
 Department of Medical Assistance Services
 600 East Broad Street, 11th Floor
 Richmond, VA 23219

If the provider is dissatisfied with the first-level appeal decision, the provider may file a written notice for a second-level appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia*, § 2.2-4000 et seq. The notice for a second-level appeal must be filed within 30 days of receipt of the first-level appeal decision. The notice for second-level appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
 Department of Medical Assistance Services
 600 East Broad Street, 11th Floor
 Richmond, VA 23219

If the provider is dissatisfied with the second-level appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The provider may not bill the recipient (client) for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.