CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PROVIDER ENROLLMENT

A participating provider is a person or organization who has a current, signed participation agreement with DMAS.

Effective April 4, 2022, all newly enrolling providers seeking to participate with Medicaid managed care or fee-for-service (FFS) must be screened and enrolled with DMAS.

DMAS's online provider enrollment process may be accessed through the Provider Enrollment link located on the DMAS Medicaid Enterprise System (MES) Provider Resources site at https://vamedicaid.dmas.virginia.gov/provider.

1. As a part of the enrollment process, providers must complete a Participation Agreement applicable to their provider type. In the case of a group practice, hospital, or other agency or institution, the authorized agent of the provider institution must sign the agreement. For group practice, hospital, or other agency or institution, DMAS must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

2. A National Provider Identifier (NPI) number must be obtained from the National Plan and Provider Enumeration System (NPPES) and provided with the enrollment application. An enrolled provider's NPI is used by MES to manage provider information across functions. For example, this number must be used on all claims submitted to DMAS.

Provider NPIs may be disclosed to other Covered Healthcare Entities pursuant to Centers for Medicaid and Medicare Services (CMS) regulations requiring the disclosure of NPIs as a part of HIPAA-compliant standard transactions. (Please reference the Healthcare Information Portability and Accountability Act (HIPAA) of 1996.)

3. Providers must have an active license from the relevant state licensing authority and provide proof of licensure during the enrollment process.

4. The provider must be successfully screened according to the requirements detailed in the next section (titled "Provider Screening Requirements").

5. Providers may be denied enrollment for any of the following reasons:
   - failing to submit any of the requested information;
   - conviction of a felony;
   - conviction of health care fraud;
   - if there are past licensure actions or actions related to privileges, enrollments, educational tenure, board certifications, authorizations, participation in health care programs, malpractice actions, liability actions, or other actions or information indicating that the individual may pose a risk to the health, safety or welfare of Medicaid members.

Providers who are located in another state but within 50 miles of the Virginia border may be permitted to enroll if all other qualifications are met. If a provider is outside of the 50-mile border of Virginia and considered an out of state provider, then a claim or supporting documentation is required to necessitate their enrollment.

6. Providers will be notified of the enrollment decision by email notice or letter mailed to the address entered in the provider enrollment portal. For denied applications, information about filing an appeal is included in the notice or letter.

7. The enrollment effective date will begin the 1st day of the month in which the application is received, unless a retroactive effective date is approved for documented extenuating circumstances.

If you have any questions regarding the enrollment process, please email Provider Enrollment Services at VAMedicaidProviderEnrollment@gainwelltechnologies.com or phone toll free 1-888-829-5373 or local 1-804-270-5105.

PARTICIPATION IN MANAGED CARE AND FEE FOR SERVICE (FFS)

Any provider of services must be enrolled with DMAS prior to billing for services rendered to eligible individuals, including individuals enrolled in either FFS or Medicaid managed care.

Most individuals who are eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS) benefits are enrolled with one of the Department of Medical Assistance Services' (DMAS') contracted Managed Care Organizations (MCOs) and receive services from the MCO's network of providers. All participating providers must confirm the individual's MCO enrollment status prior to rendering services. The MCO may require a referral, service authorization or other action prior to the start of services. All providers are responsible for adhering to state and federal requirements, their MCO provider contract(s) (as applicable), and the applicable DMAS provider manual. For providers to participate with one of DMAS' contracted MCOs, they must also become a participating provider in the MCO's network.

Please visit the DMAS website at https://vamedicaid.dmas.virginia.gov/provider for more information on participation with the Medicaid FFS and managed care programs

Carved-Out Services

Regardless of an individual's MCO enrollment, some services are "carved-out" of the managed care program and are paid directly by DMAS using FFS methodology. Providers must follow the FFS rules in these instances.

Individuals who receive services under one of the three 1915(c) Developmental Disabilities Home and Community-Based Services (HCBS) Waivers, including the

Building Independence, Community Living, and Family and Individual Supports Waivers, are enrolled in managed care for their non-waiver services (e.g., acute, behavioral health, pharmacy, and non-waiver transportation services). The individual's waiver services benefits are carved-out and managed directly by DMAS.

PROVIDER SCREENING REQUIREMENTS

The 21st Century Cures Act (Cures Act)114 P.P.255 requires all states to screen Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) upon enrollment. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every five (5) years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate", or "high."

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations and State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

In addition to the screening requirements applicable to the limited risk provider category listed above, unannounced pre- and/or post-enrollment site visits apply to moderate risk providers. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every five (5) years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submit fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation, and when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice.

CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination may be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Screening

Prior to enrollment in DMAS, providers with a primary servicing address located outside of the Virginia border must have a site visit conducted by either their state’s Medicaid program or by CMS due to their provider risk-level. Pursuant to 42 CFR 455 Subpart E, an application will be pended for proof of this information if it is received by DMAS prior to the completion of the site visit.

Revalidation Requirements

All participating providers are required to revalidate at least every five (5) years. Providers are notified in writing of their revalidation due date and of any new or revised provider screening requirements. (Providers will indicate their preferred mode of notification, i.e., email or USPS, at the time of enrollment.) DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements if a provider is enrolled as a Medicare provider at the time of revalidation.

ORDERING, REFERRING, AND PRESCRIBING (ORP) PROVIDERS

42 CFR 455.410(b) states that state Medicaid agencies must require all ordering, or referring, and prescribing physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ORP providers to enroll to meet new program integrity requirements designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid members originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. There is one exception: the provider enrollment requirements do not apply to physicians who order or refer services for a Medicaid member in a risk-based managed care plan.

If a provider does not participate with Virginia Medicaid currently but may order, refer, or prescribe to Medicaid members, they must be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Virginia Medicaid Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking waiver services or medical care from any institution, pharmacy, provider, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject supports, medical care and treatment.
- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals in amounts not to exceed the provider's usual and customary charges to the general public.

- The provider shall submit all other available third-party payment sources prior to submitting a claim to DMAS or the MCO, as applicable. Notwithstanding this, the Provider shall not request, pursue (e.g., assignment of rights by member or member's representative) or accept payment for medical services from any tortfeasors or their carrier arising from a bodily injury claim (for example, motor vehicle, or homeowner's insurance).

- The provider and its vendors must submit claims for medically necessary, Medicaid-covered services to DMAS or the MCO, as applicable, provided that the member has supplied information to verify the member's Medicaid enrollment at least 21 days before the claim submission deadline. A provider that does not comply with this requirement agrees not to bill the member for such services or assert any contractual assignments, benefits, rights to reimbursement, or statutory liens against the member.

- Accept assignment of Medicare benefits for eligible individuals.

- Use DMAS-designated billing forms to submit claims.

- Maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the health care services provided. In general, such records must be retained for a period of not less than six years from the 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 must be retained until the audit is completed and every exception resolved.

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

- As requested by DMAS, disclose all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to eligible individuals.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. 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.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

In order to comply with Federal Regulations and Virginia Medicaid Program policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by individuals or entities that have been excluded from participation in any state Medicaid Program or Medicare.

Payments cannot be made for items or services furnished, ordered, or prescribed by an excluded provider or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the payment is made to another provider, practitioner, or supplier that is not excluded, but is affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by the Virginia Medicaid Program may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to meet Federal and Virginia Medicaid program integrity requirements:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in Medicaid or Medicare. (Go to https://oig.hhs.gov/exclusions/)

- Search the Health and Human Services Office of the Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs.

- Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions 600 E. Broad St, Suite 1300
Richmond, VA 23219
-or-
E-mailed to: providerexclusions@dmas.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §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, all

Medicaid providers are responsible for making provisions for individuals with disabilities in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of 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 basis of race, color, religion, sex, or national origin.

UTILIZATION OF INSURANCE BENEFITS

Virginia Medicaid is a "payer of last resort" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- Workers' Compensation - No payments shall be made for a patient covered by Workers' Compensation.

- Other Health Insurance - When an eligible individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), the Virginia Medicaid Program requires that these benefits be used first. Supplementation shall be made by the Virginia Medicaid Program when necessary, but the combined total payment from all insurance, shall not exceed the amount payable under Medicaid had there been no other insurance.

- Liability Insurance for Accidental Injuries - DMAS will seek repayment from any settlements or judgments in favor of eligible individuals who receive medical care as the result of the negligence of another. DMAS should be notified promptly if an eligible individual is treated as the result of an accident so action can be initiated to establish a lien as set forth in the Code of Virginia §8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. The form can also be sent electronically to TPLcasualty@dmas.virginia.gov

DOCUMENTATION REQUIREMENTS

The Virginia Medicaid Program provider participation agreement requires that medical records fully disclose the extent of services provided to all Medicaid members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and the description of the services rendered must be clear. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery.

ELECTRONIC SIGNATURES

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of the electronic signatures for clinical documentation purposes shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers shall have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use electronic signatures shall sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use shall be maintained and available at the provider’s location.

Additionally, the use of electronic signatures shall be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records.

TERMINATION OF PROVIDER PARTICIPATION

The provider participation agreement is time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to DMAS 30 days prior to the termination's effective date. The written notification should be sent to the following address:

DMAS Provider Enrollment Services
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider's participation agreement. DMAS must provide written notification 30 days prior to the termination's effective date. Such action precludes further payment by DMAS for services provided to customers after the date specified in the termination notice.

Pursuant to §32.1-325 (D) of the Code of Virginia, the DMAS Director of Medical Assistance Services is authorized to:

Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

Appeals of Provider Termination or Enrollment Denial: A provider has the right to appeal in any case in which a Virginia Medicaid Program provider agreement or contract is terminated or denied pursuant to Virginia Code §32.1-325(D). The provider may appeal the decision in accordance with the Administrative Process Act (Code of Virginia §2.2-4000 et seq.) and the Provider Appeals regulations (12 VAC 30-20-500 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

APPEALS OF ADVERSE ACTIONS

There are two types of appeals – client and provider. In a client appeal, the patient, their

parent or guardian, or an authorized representative has the right to appeal for services not yet rendered. Please refer to Chapter III for more details on the client appeal process. In a provider appeal, a provider or its authorized representative has the right to appeal.

An appeal is an independent review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. For provider appeals, an adverse action can be:

1. Any negative action on payment for a service the provider has already given to the patient. A negative action can be: (a) a termination, suspension, reduction, or denial of authorization; (b) a claim denial; or (c) an audit determination.
2. Denial or termination of enrollment as a DMAS participating provider.

Appeals are processed in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*., Code of Virginia § 32.1-325.1, and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

PROVIDER APPEALS: NON-STATE-OPERATED PROVIDERS

The following procedures apply to all providers not operated by the Commonwealth.

Before the Appeal: Reconsideration Requirements

If an MCO, Acentra, or DentaQuest took the adverse action, the provider must exhaust the reconsideration process with that contractor **before** the provider can appeal with DMAS. DMAS will dismiss appeal requests made before the final reconsideration. If the reconsideration is final, the notification letter will state so and include instructions on how to request an appeal with DMAS.

If DMAS took the adverse action, the provider must request reconsideration if the action involves a DMAS claim under the Enhanced Ambulatory Patient Grouping (EAPG) payment methodology or a ClaimCheck denial. The deadline to request reconsideration for these claims is 30 days from when the provider received written notice of the adverse action. The provider must include all supporting documentation with the reconsideration request.

Address the EAPG or ClaimCheck reconsideration request to the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street, Richmond, Virginia 23219

The Program Operations Division will review the reconsideration request and provide a written response.

If the reconsideration partially or completely upholds the adverse action, or reconsideration is not required, the provider may request an informal appeal with the DMAS Appeals Division.

Stages of Provider Appeals

There are two stages of provider appeals: informal and formal.

For informal appeals, an informal appeals agent conducts an impartial review of the adverse action and issues the informal appeal decision. An informal appeal decision must be issued before a provider can request a formal appeal.

For formal appeals, a hearing officer is selected from a list maintained by the Supreme Court of Virginia. The hearing officer sends a recommended decision to the Agency Director, who then issues the final agency decision.

Appeal Requests

How to Request an Appeal

Effective November 5, 2026, all providers must request appeals through the Appeals Division's online portal, the Appeals Information Management System ("AIMS"). Providers must have an AIMS account to request an appeal.

Provider registration requests must be reviewed before the account is created. As a result, providers will not have an AIMS account immediately after registering. Providers are encouraged to register for AIMS even if they do not need to file an appeal.

Providers can register for and access AIMS at www.dmas.virginia.gov/appeals.

Exception to the Portal Filing Requirement

Providers who are unable to file an appeal request through AIMS can request an exception. The request must have a subject of "Exception Request for Portal Filing." For emails, this must be in the subject line. For delivered requests, this must be underneath the address block on the cover letter. The request must be filed prior to the appeal request deadline.

Exceptions will be granted for good cause shown. Examples of good cause include:

1. The infrastructure necessary to support electronic submission is not available in the provider's geographic region;
2. The disability of all members of a provider's staff prevents their use of AIMS; or
3. The provider cannot transmit documents through AIMS due to unusual or unavoidable circumstances.

Providers can request an exception using any of the following methods:

1. Email the exception request to appeals@dmas.virginia.gov.
2. Mail or bring the exception request to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

If the DMAS Appeals Division grants an exception to the portal filing requirement, the provider must file an appeal request through email, postal mail, or hand delivery, prior to the appeal request deadline. See 12VAC30-20-520 for more information.

Multiple Appeal Requests

Providers must submit a new appeal request for each appealable notice received.

Filing Date

A provider's appeal request is filed when it completes transmittal to AIMS.

If the DMAS Appeals Division grants an exception to the portal filing requirement, the provider's appeal request is filed when it is date-stamped by the DMAS Appeals Division. See 12VAC30-20-520 for more information.

The Department of Medical Assistance Services' normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern Time. If a provider submits documents or correspondence to the DMAS Appeals Division after 5:00 p.m., DMAS will date stamp the document or correspondence on the next day the Department is officially open. If a provider sends a document to the DMAS Appeals Division after 5:00 p.m. on the deadline date, it is untimely.

Communication Options

Providers must upload all documents, correspondence, and other items to AIMS. The Appeals Division will not accept items a provider sends through any other method unless the Appeals Division granted the provider's request for an exception from the portal filing requirement.

The Appeals Division will send all documents and correspondence through AIMS. The Appeals Division will send an email notification to the provider's point of contact when an item is ready to review in AIMS. The Appeals Division will not directly email electronic copies of documents or correspondence to the provider's point of contact; for security reasons, the email will only contain a link to log in to AIMS to review the documents. The Appeals Division presumes the point of contact receives all items when the Appeals Division sends the email notification to the point of contact.

For technical assistance with AIMS, contact AIMS Help at aimshelp@dmas.virginia.gov or 804-486-2865.

If the Appeals Division grants an exception to the portal filing requirement, the Appeals Division will send all documents and correspondence to the postal mail address listed in the provider's exception request. The provider may transmit items through email, mail, or hand delivery. See 12VAC30-20-520 for more information on filing documents after an exception request is granted.

Administrative Dismissals

Informal Appeals

The Appeals Division will administratively dismiss an informal appeal if:

- A provider fails to request an informal appeal before the applicable deadline.
- DMAS requests proof that an individual or entity is authorized to pursue the appeal and the provider does not return the required paperwork by the deadline.

- A provider has not exhausted the DMAS or contractor's reconsideration, review, or internal appeal process, if the process is required before filing a DMAS informal appeal.

An administrative dismissal is an informal appeal decision dismissing the informal appeal without any further proceedings. If a provider's informal appeal results in an administrative dismissal, the provider will have the right to appeal the dismissal.

Formal Appeals

The Appeals Division cannot administratively dismiss formal appeals.

Appeal Request Timeframes

Informal Appeals

The informal appeal request timeframe begins when a provider receives notice of the adverse action. The appeal request deadline depends on the type of appeal the provider requests.

The deadline to request an appeal of a DMAS provider agreement termination is **15 calendar days**.

The deadline to request an appeal of adjustments to a cost report is **90 calendar days**.

The deadline is **30 calendar days** for:

- Any payment-related action that does not involve adjustments to a cost report.
- Any other adverse action not stated above.

Formal Appeals

Any provider appealing a DMAS informal appeal decision must file a formal appeal request with the DMAS Appeals Division. The formal appeal request must identify the informal case(s) that are being appealed. The deadline is **30 calendar days** from the provider's receipt of the DMAS informal appeal decision. Failure to file a formal appeal request within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal.

Circuit Court Appeals

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et seq*. and the Rules of the Supreme Court of Virginia.

Repayment

Virginia Code § 32.1-325.1 requires DMAS to collect identified overpayments. Repayment must be made upon demand unless DMAS agrees to a repayment schedule. If a provider does not repay DMAS in a lump sum cash payment, DMAS will add interest on the declining balance at the statutory rate, pursuant to Va. Code § 32.1-313.1. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates a financial hardship warranting extended repayment terms. The provider must demonstrate the hardship to the satisfaction of DMAS.

DMAS and associated contractors (e.g. MCOs) cannot collect repayment or apply interest during the administrative appeal.

The provider must not bill the member for covered services that have been provided and subsequently denied by DMAS.

PROVIDER APPEALS: STATE-OPERATED PROVIDERS

The following procedures apply to all Medicaid-enrolled providers operated by DMAS.

Reconsideration

A state-operated provider has the right to request a reconsideration of any issue that the State Plan allows a non-state operated provider to appeal. This is the sole procedure available to state-operated providers.

The reconsideration process has three steps:

1. An informal review by the Division Director.
2. A review by the DMAS Agency Director.
3. A Secretarial review.

1. Informal Review

For Step One, the state-operated provider must submit written information specifying the nature of the dispute and the relief sought to the appropriate DMAS Division Director. DMAS must receive this request 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 provider seeks a reimbursement adjustment, the written information must include the nature of the adjustment, the amount of the adjustment, and the reason(s) for seeking the adjustment. Upon request by either party, DMAS may arrange an informal meeting to discuss a resolution.

The Division Director or a designee will review the information and request additional information if necessary. The designee will then recommend to the Division Director whether relief is appropriate under applicable laws and regulations. The Division Director shall consider any recommendation of the designee and render a decision.

2. Agency Director Review

Step Two permits a state-operated provider to request the DMAS Agency Director review the Division Director's decision. The state-operated provider must request the Agency Director's review within 30 days after receipt of the Division Director's decision. The DMAS Agency Director may appoint a designee to review the Division Director's decision. The DMAS Agency Director has the authority to take whatever measures the Agency Director deems appropriate to resolve the dispute.

3. Secretarial Review

Step Three occurs when the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider. Step Three permits the provider to request the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. The state-operated provider must request referral for Secretarial review within 30 days after receipt of the DMAS Agency Director's Decision. Any determination by such Secretary or Secretaries is final.

AREAS OF SERVICE – CCC+ WAIVER

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).

PERSON-CENTEREDNESS

As a core tenet of Home and Community-Based Services, all providers of CCC Plus Waiver services must engage with the waiver individual with a person-centered approach. Person-centered planning is a requirement of HCBS, but good person-centered thinking and planning allows all parties involved to reach the person's vision for their preferred life with optimal outcomes including independence, good health, and quality of life. Person-centered plans help create a system where waiver individuals can live their lives by making informed choices, having full control, and accessing the array of quality services.

The National Center of Advancing Person-Centered Practices and Systems (NCAPPS) defines the following terms that focus on the individual first and foremost:

- Person-Centered Thinking: the means for a person to live a life that they and the people who care about them have good reason to value.
- Person-Centered Planning: a way to assist people who need HCBS and supports to construct and describe what they want and need to bring purpose to life.
- Person-Centered Practice: the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

In developing a person-centered plan, providers must work with the individual to document ***what is important to*** and ***what is important for*** the individual. What is important to an individual are the relationships, personal control, the individual's routines and pace of life; the places, activities, and experiences that the individual wants or likes to do or to have; and the physical things that are important to the individual. What is important for the individual may include social rules, the individual's contributions and role in the community; their health status; diet and exercise; and topics of safety.
developing the person-centered plan, providers should, at a minimum, adhere to the following requirements:

- Let the individual, even if a minor, lead the discussion to the extent possible. The individual can have a representative to participate, as needed and to the extent defined by the individual, in the process; however, the individual's opinions and voice should be considered first and foremost in the process. In addition to their representative, the individual has the right to have other people involved at their choosing in the planning process, such as family members, friends, or neighbors;
- Provide information and supports on all available services in the waiver, other Medicaid and non-Medicaid services and supports that may be available, and additional assistance so that the individual is able to direct the process to the extent possible and enabled to make informed choices and decisions;
- Is performed timely and at a time and place of the individual's choosing;
- Reflects the individual's strengths and preferences plus individually identified goals and desired outcomes;
- Reflects cultural considerations of the individual and conducted using plain language and in a way that is accessible to the waiver individual, which would include the provider's use of interpretation services if the individual has a limited English proficiency (use of a family member to translate or interpret is not acceptable);
- Identifies risk factors and includes measures in place to minimize them;
- Discuss possible areas of conflict, disagreement, or conflict of interest during the process that includes written documentation wherever the individual, individual's representative, or provider disagree so that objections are noted; and
- Record alternative services, supports, and settings that were discussed and considered with the individual but were not selected.

The person-centered planning process must be reviewed on an annual basis and may be updated more frequently as needed. The person-centered plan is meant to be a document that empowers individuals to build the life they want at that particular moment in their life; all individuals change as they get older and have new experiences and outlooks on life, and just as the aspirations and goals of those who do not have a disability change over time, so too should it be expected that the person-centered plans of waiver individuals show changes in preferences, goals, and outcomes.

The person-centered plan must be agreed to by the individual and signed by the individual. If the individual is a minor, the individual's representative must also sign. If the individual does not agree to the plan due to a reasonable objection, such as the provider has not documented the individual's preferred services, supports, or caregivers or that the individual feels their personal wants and goals have not been addressed due

to provider or other external interference, then the plan is not person-centered and must be adjusted. If the reason for the individual's objection is one where the provider and other individuals in the planning meeting have raised and documented their concerns that the individual's preferences are likely to lead to health, safety, and welfare issues or are entirely unrealistic, then those in the meeting should work with the individual to develop a more reasonable plan that addresses ways to reduce the possibility of those issues and provides a more realistic path towards achieving the individual's dreams and goals.
person-centered plans must ensure freedom of and respect for choice to individuals. This includes the individual's right to choose from nursing facility, PACE or HCBS care as well as identification of the individual's choice of pharmacy, practitioner, or other provider qualified and enrolled in Medicaid to provide the services identified and selected. Person-centered plans should document the individual's goals.

INDIVIDUAL CHOICE OF PROVIDER

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

At the time individuals are approved for services, the Long-Term Services and Supports (LTSS) Hospital or Community Screening 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.

DIRECT MARKETING

All participating Medicaid providers are prohibited from performing all types of direct marketing activities to Medicaid individuals. "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 individuals as inducements to use their services; continuous, periodic marketing activities to the same prospective individual (e.g., monthly, quarterly, or annual giveaways) 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 individuals' use of providers' services.

CRIMINAL BACKGROUND CHECKS

In accordance with Virginia Code § 32.1-162.9:1, any licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8 or any licensed hospice as defined in § 32.1-162.1, shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in Code of Virginia § 32.1-162.9:1 or an original criminal history record from the Central Criminal Records Exchange. However, no employee shall be permitted to work in a position that

involves direct contact with a patient until an original criminal record clearance or original criminal history record has been received, unless such person works under the direct supervision of another employee for whom a background check has been completed in accordance with the requirements of § 32.1-162.9:1 of the Code of Virginia.

Subsection C. of Virginia Code § 32.1-162.9:1 states as follows: "A person who complies in good faith with the provisions of this section shall not be liable for any civil damages for any act or omission in the performance of duties under this section unless the act or omission was the result of gross negligence or willful misconduct." Accordingly, this provision does not apply to audits or administrative actions by DMAS to recover a Medicaid overpayment made to a provider.

Providers must keep proof that an original criminal record check from the Central Criminal Records Exchange and a search of the VDSS Child Protective Services (CPS) Central Registry, as applicable, was requested and conducted for each staff member hired.

PARTICIPATING AGENCY-DIRECTED PERSONAL/RESPITE CARE PROVIDER

A participating personal/respite 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. 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/respite 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/respite care providers provide services designed to prevent or reduce institutional care by providing eligible individuals 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/respite care as a part of the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The personal/respite care provider will be reimbursed according to the fee schedule (available on the DMAS website (www.dmas.virginia.gov). 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.

In order to be enrolled as a Medicaid provider for the personal care or respite service, the provider must be licensed or accredited by one of the following:

- Accreditation Commission for Health Care, Inc. Certification (ACHC)
- Centers for Medicare and Medicaid Services (CMS) Certification
- Community Health Accreditation Program Certification (CHAP)
- Joint Commission on Accreditation for Health Care Organizations (JCAHO) Virginia Department of Health (VDH) Home Care Organization (HCO) License

PROVIDER PARTICIPATION STANDARDS FOR AGENCY-DIRECTED PERSONAL/RESPITE 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 for Personal Care and Respite Care Services

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 and licensed practical nurses (LPN). The RN must possess the following qualifications:

   - A license to practice in the Commonwealth of Virginia;
   - At least one (1) year of related clinical experience as a RN or a LPN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility.
   - 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 or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adults or children is acceptable.
   - The RN must submit to a criminal record check obtained through the Virginia State Police. If the individual receiving services is a minor, the RN must also submit to a search of the VDSS Child Protective (CPS) Central Registry. The provider must not hire any RN with findings of barrier crimes identified in 32.1-162.9:1 of the *Code of Virginia* or founded complaints in the CPS Central Registry.

     Documentation of license, clinical experience, references, and evidence of a criminal background record check and central registry search if applicable must be maintained in the RN's personnel file for review by DMAS staff or its contractors.

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;
- Ability to create and maintain required documentation
- Have the required skills to perform the services;
- Have a valid social security number; 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.

DMAS requirements may be met in one of four 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 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.

2. Graduation from a Board of Nursing 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.

3. Training from an educational/medical institution: Numerous hospitals, nursing facilities, and educational institutions provide nursing assistant training that is not Board of Nursing-approved (e.g., out-of-state curricula). This type of nursing assistant training is acceptable to meet DMAS requirements for personal care aides. Providers must obtain documentation from the educational or medical institution confirming the personal care aide successfully completed the course. This must be done prior to offering employment for Medicaid-reimbursed services.

4. A provider may develop and offer a 40 hour training program incorporating all the following elements:

   Goals of Personal Care, Prevention of Skin Breakdown, Physical and Biological Aspects of Aging, Physical and Emotional Needs of Older Adults,

Orientation to Types of Physical Disabilities, Personal Care and Rehabilitative Services, Body Mechanics, home management, Safety and Accident Prevention in the Home, Accident Prevention, Typical Hazards in the Home, Policies and Procedures Regarding Accidents or Injuries, Food, Nutrition, and Meal Preparation, Importance of Nutrition to the Individual, General Concept of Planning Meals, Special Considerations in Preparation of Special Diets, Food Purchasing and Preparation, Care of the Home and Personal Belongings, and Documentation Requirements for Medicaid Individuals.

This training must be conducted by a registered nurse who meets the RN staffing requirements for personal care/respite providers. ALL graduates from the 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 was received prior to assigning an aide to provide services for an individual. Based on continuing evaluations of the aide's performance and the individual individual's needs, the RN Supervisor shall identify any significant gaps in the aide's ability to function competently and shall provide the necessary training.

In addition to the initial training requirements for personal care aides, each aide must have a minimum of 12 hours of training annually. The year is based on the aide's hire date. This training is provided by the provider agency and must be related to the performance of personal care services. Documentation of this training must be kept in the employee's personnel files, including a description of the training, the date performed, the length of time taken, and a signature with title of the administrator of the training confirming that the aide satisfactorily completed the 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 the aide has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable. 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 or its contractors.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The personal care aide must submit to a search of the VDSS

Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. **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* or has a founded complaint confirmed by the CPS Central Registry.**

The provider must have documentation proving that a criminal background check and CPS Central Registry check if applicable was requested and obtained. This documentation must be made available to DMAS staff or its contractors, upon request.

Payment may be made for services rendered by family members or caregivers living under the same roof as the individual receiving waiver services only when there is written, objective documentation as to why no other aide or provider is able to render services to that individual. The family member or caregiver providing personal care services to the individual must meet the same requirements as other aides. This documentation is not required for a legally responsible individual (natural, adoptive, or foster parent; stepparent; or legal guardian of a minor under the age of 18 or a spouse).

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

No aide may work more than 16 hours in a day, starting at 12AM and ending at 11:59PM, providing Medicaid-reimbursed personal care and/or respite services.

3. Licensed Practical Nurse (LPN)

Each LPN hired by the provider must be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Basic qualifications for LPNs include:

- The LPN must be able to practice in the Commonwealth of Virginia;
- Have at least one (1) year of related clinical experience as a LPN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility.
- 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 or children, recorded in the nurse's personnel file. If the LPN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The LPN must submit to a search of the VDSS Child

Protective Services (CPS) Central Registry if the individual receiving services is a minor child. **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* or has a founded complaint confirmed by the CPS Central Registry.**

The provider must have documentation proving that a criminal background check and CPS Central Registry check, if applicable, was obtained. This documentation must be made available to DMAS staff or its contractors, 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.

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

PARTICIPATING QUALIFICATIONS FOR PRIVATE DUTY NURSING/SKILLED RESPITE PROVIDERS

A participating Private Duty Nursing (PDN)/skilled respite 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. 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. A provider may, however, choose to offer only one of the two services.

PDN/skilled respite care providers provide services designed to prevent or reduce institutional care by providing eligible individuals with nurses who perform skilled tasks that go beyond basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of PDN/skilled respite care as a part of the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The provider will be reimbursed according to the fee schedule (available on the DMAS website (www.dmas.virginia.gov). 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.

In order to be enrolled as a Medicaid provider for PDN or skilled respite service, the provider must be licensed or accredited by one of the following:

- Accreditation Commission for Health Care, Inc. Certification (ACHC)
- Centers for Medicare and Medicaid Services (CMS) Certification
- Community Health Accreditation Program Certification (CHAP)

- Joint Commission on Accreditation for Health Care Organizations (JCAHO)
- Virginia Department of Health (VDH) Home Care Organization (HCO) License

NURSING QUALIFICATIONS FOR PRIVATE DUTY NURSING SERVICES

RN Supervisors

- RN supervisors shall be verified as currently licensed to practice nursing in the Commonwealth;
- Have at least one year of verified related clinical nursing experience which may include work in an acute care hospital, long stay hospital, rehabilitation facility, or specialized care nursing facility; and
- Previous nursing experience shall be documented in his/her agency personnel file.

Private Duty Nurse – RN or LPN

- The private duty nurse (PDN) must either be a licensed practical nurse (LPN) or a registered nurse (RN) with a current and valid Virginia license;
- The decision to assign a RN or LPN must be based on the needs of the individual and the nurse's license restrictions;
- A LPN cannot be assigned to perform activities which fall outside the nursing practices allowed and which should be performed by a RN;
- RN “applicants” do not meet the Medicaid requirement of having a valid Virginia nursing license; and
- A private duty nurse must demonstrate specialized experience and proficiency with delivery of nursing care to any population which has specialized needs (e.g., a ventilator-dependent individual) prior to assignment to such an individual.

All RNs and LPNs who provide skilled private duty nursing (PDN) services shall have either:

- A minimum of six months of clinical experience related to the care needs of the assigned waiver individual such as ventilator, tracheostomy, nasogastric tube, etc. (documented in their personnel file), that may include work in acute care hospitals, long stay hospitals, rehabilitation facilities, or specialized care nursing facilities; or

- Have completed a provider training program related to the care and technology needs of the assigned waiver individual; and
- Have a completed TB test and current CPR certification.

Nursing agencies that do not have a training program that meets the DMAS training program criteria shall continue to provide nurses with at least six (6) months of previous experience in the skills applicable to CCC Plus waiver individuals to provide safe care (tracheostomies, ventilators, etc.).

Training programs established by providers shall include, at a minimum, the following:

- Trainers (RNs or Respiratory Therapists (RT) shall have at least six months clinical ("hands- on") experience in the areas they are providing training in such as ventilators, tracheostomies, peg tubes, and nasogastric tubes. This experience must be documented in their personnel file or training records.

- Training shall include classroom time as well as direct clinical ("hands-on") demonstration of mastery of these skills by the trainee.

- The training program shall include the following subject areas as they relate to the care to be provided by the PDN nurse:

    - Human Anatomy and Physiology
    - Medications frequently used by technology dependent individuals
    - Emergency management of equipment and individuals
    - The operation of the relevant equipment.

Providers shall assure the competency and mastery of the above skills necessary to successfully care for the CCC Plus waiver individual by the nurses prior to assigning them to the individual. Documentation of successful completion of such training course and mastery of these skills shall be maintained in the provider's personnel records. The documentation shall be provided to DMAS or its contractors, upon request.

Documentation of the PDN's knowledge, skills, abilities and experience in the care of individuals with special needs and current CPR certification must be included in the nurse's personnel file. This information is recorded on the "CCC Plus Waiver Private Duty Nursing Skills Checklist" (DMAS 259) which must be fully completed, signed and fully dated by the nurse supervisor prior to the assignment of a PDN to a waiver individual. The DMAS-259 Skills Checklist is recommended for use by all PDN providers and can be located on the Medicaid Web Portal under the MES Forms Library. A skills checklist may be developed by the provider which contains all of the components of the DMAS-259 form.

For a newly admitted waiver individual, the DMAS 259 must be completed by the nursing supervisor for all nurses assigned to the individual. When a waiver individual has been receiving services and a new nurse is assigned, the primary nurse can complete the orientation if he or she is an RN. If the primary nurse is a LPN, the nursing supervisor is responsible for the orientation and completion of the DMAS-259.

Nurses providing skilled PDN or respite care services cannot be parents (i.e.: natural, step-parent, adoptive, foster, or legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual for the purpose of Medicaid reimbursement under the CCC Plus

waiver.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The RN/LPN must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. **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* or has a founded complaint confirmed by the CPS Central Registry.**

The provider must have documentation proving that a criminal background check and CPS Central Registry check, if applicable, was requested and obtained. This documentation must be made available to DMAS staff or its contractors, upon request. The actual background check results must not be maintained in the record but should be securely disposed.

PARTICIPATION STANDADS FOR ADULT DAY HEALTH CARE (ADHC)

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 center, meets the standards and requirements set forth by DMAS, and has a current, signed Participation Agreement with DMAS.

ADHCs offer community-based day programs providing a variety of health, therapeutic, and social services designed to meet the specialized needs of older adults and individuals who have a physical disability. ADHC services enable individual to remain in their communities and to function at the highest level possible by augmenting the social support system already available to the individual, rather than replacing the support system with more expensive institutional care. The ADHC is reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). 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.

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

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

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

HCBS SETTINGS COMPLIANCE

Home and Community-Based Services (HCBS) Waivers provide Virginians enrolled in Medicaid long-term services and supports the option to receive community based services as an alternative to an institutional setting. Per federal regulations (42 CFR 441.301), provider operated or controlled settings must have the following characteristics:

- The setting must be integrated in and supports full access to the greater community. This includes opportunities to engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
    - Rules and practices that facilitate community access should be established. When providing HCBS, individuals should not be isolated from those who do not have disabilities. Providers must ensure that practices do not create an environment that is institutional in nature. This includes the ability to come and go from settings (with appropriate supports) and provider support to individuals who express a desire to participate in the community by providing opportunities for new experiences.

- The setting must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
    - People in HCBS have the right to be treated with respect and dignity in all facets of life. This includes respecting people’s likes and dislikes, treating them in a way that makes them feel respected and heard, and assisting people with supports in a compassionate manner that preserves their privacy and dignity. Examples of providing services with dignity include, but are not limited to:
        - Addressing individuals by their preferred name and not nicknames that are not preferred or calling the individual by endearments such as baby, sweetie, or honey;
        - Wearing typical clothing while providing supports such that the greater community is unable to distinguish that an individual is receiving paid supports (vs. scrubs, uninforms, or clothing items with provider agency logos);
        - Providing individuals with discreet and appropriate storage areas for personal items such as incontinence supplies and personal care items;
        - Knocking on a bathroom door and getting permission for entry before entering (unless there is an emergency);
        - Maintaining a setting that is free from institutional traits and signage such as conspicuously posted memos/training for staff, staff sign in/out logs, reminders and notices for staff, and any important information pertaining to the protected health information (PHI) and

personally identifiable information(PII) of an individual in the setting;
- Utilizing person-first language in verbal and written documentation and refraining from language that would be demeaning to an individual using HCBS services. Examples of outdated and demeaning language may include mental retardation, client, consumer, wheelchair bound, etc. Dignified language would include person with a disability, individual, a person's name, person who uses a wheelchair.

- The setting must optimize, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
  - People retain the ability to make choices about how they spend their time in any given setting and have opportunities to participate in age-appropriate activities. Providers must engage with the individual and the team using person-centered thinking to ensure that:
    - Individuals are supported in life-informed "real" choices and autonomy;
    - Individuals are offered actual experiences on which they can base future choices;
    - Plans are created with the appropriate balance between autonomy and safety.

- Individuals' personal preferences are made a priority. When there is a difference of opinion with an individual (or, if the individual is unable to make decisions for his/herself, a parent or guardian) or provider preference (unless for a documented health and safety), there should be open dialog in order to come to an agreement
  - Individuals are supported and inspired to work towards their goals, dreams, and priorities;
  - Individuals' choices regarding services and supports, and who provides them are facilitated. If an individual wishes to change their services or support, they can do so without fear of retaliation or coercion by the current service or support provider, including family members;
  - Individuals' choices to decline activities or supports are respected. This includes staying home rather than attending ADHC. Individuals should be informed about potential risks or natural consequences of their choices, and this should be documented and re-evaluated with the individual on a regular basis;
  - All providers should be providing individualized services in accordance with the Person-Centered Service Plan.

- Individuals control their day-to-day lives the same way other community members do. This includes control over planning their own daily schedules and activities and choosing when and what they eat. This includes the ability to choose not to participate in scheduled activities. Individuals have freedom and support to control

their own schedules and activities and have access to food at any time.

- The setting is physically accessible to the individual. Providers must provide adaptations for physical accessibility for those who need supports to move about the setting. All common areas must be accessible to the individuals in the setting. This includes all areas that would be used in typical daily activities including general spaces, kitchens, dining rooms, pantry/food storage, bathrooms, and any office area within the ADHC. Adaptations for physical accessibility may include, but are not limited to:

    - Grab bars;
    - Seats in the bathroom;
    - Ramps for wheelchairs;
    - Viable exits for emergencies;
    - Accessible appliances to individuals; and
    - Tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably.

- The setting must facilitate individual choice regarding services and supports, and who provides them.

- Use the information and resources provided to critically evaluate each setting's compliance with these standards and to develop strategies to ensure individual's rights are supported and achieved.

- The setting must develop a Home and Community Based Services Rights Policy. This policy must be inclusive of the following:

    - A specific outline of the rights afforded to people receiving HCBS services (including a value on community and personal interests);
    - A person-centered planning policy;
    - All documentation, including a disclosure form, about the HCBS Settings Rule, Person Centered Planning, and the rights of each individual are in a significant and understandable manner and are provided to the individual or designated representative for review and signature upon admission and annually thereafter (with a copy provided to the individual/family/caregiver after signature); and
    - Agency policy and appropriate documentation that new employees, contractors, students, and volunteers are trained in HCBS rights upon orientation and annually thereafter.

Prior to ADHC enrollment, providers must complete a HCBS Provider Self Assessment. The provider can get access to the assessment, additional information, reference materials, and further instructions by accessing the HCBS Toolkit at https://dmas.virginia.gov/for-members/benefits-and-services/waivers/home-and-community-based-services-toolkit/ Interested Adult Day Centers interested in meeting

compliance with the Settings Rule to be enrolled as an ADHC should review only the ADHC portions of the toolkit. Once completed, the Adult Day Center may email the completed HCBS Provider Self Assessment to hcbscomments@dmas.virginia.gov for review and compliance verification by DMAS staff. Once the ADHC is determined compliant, they will receive a DMAS Compliance Letter. The ADHC will send a copy of the letter to DMAS Provider Enrollment Services Unit when applying for the NPI number.

Individual 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 individual. 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 individual needs.

“Staff” is defined as professional and aide staff.

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

Adult Day Health Care (ADHC) Minimum Staffing Requirements

The ADHC Center will always maintain a minimum staff-individual ratio of one staff member to every six individuals (Medicaid and other participants).

There shall be at least two (2) staff persons at the ADHC Center at all times when there are Medicaid individuals in attendance.

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

Volunteers shall be included in the staff-individual 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- individual ratio.

Any ADHC Center that is co-located with another facility shall count only its own separate identifiable staff in the Center’s staff-individual ratio.

The ADHC Center must employ staff sufficient to meet the needs of the individuals.

These staff include the:

Director - Responsible for the overall management of the ADHC Center’s programs and employees. This individual is the provider contact person for the service authorization contractor and is responsible for participation agreements and receiving and responding

to communication from DMAS. The Director is responsible for ensuring the initial development of the Plan of Care (DMAS-301) for individuals;

Activities Director – Responsible for directing the recreational and social activities of the ADHC recipients.

Personal Care Aides - Responsible for overall care and assistance to the individual (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 individual. The RN is responsible for the planning, organization, and management of a Plan of Care (POC) 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 individuals receiving Medicaid ADHC individual services. DMAS does not require that the nurse be a full-time staff position, but the nurse's schedule must be arranged so that each individual is seen every month. There must be a RN available by telephone at a minimum to the ADHC Center's staff and individuals receiving ADHC services 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 individuals receiving services. 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 individuals in the ADHC Center and the overall functional level or specialized needs of those individual.

The Director will assign a professional staff member to act as ADHC Coordinator for each individual. The identity of the ADHC Coordinator must be documented in the individual's file. The ADHC Coordinator is responsible for management of the individual's Plan of Care and reviews the individual's Plan of Care with the program aides. In cases where the individual only receives ADHC and PERS the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

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 with any new tasks. If the individual'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 of the task.

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

A multi-disciplinary approach to problem identification, individual 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

Personal Care Aide

Each program aide hired must be evaluated by the provider to ensure compliance with minimum qualifications required by DMAS. Basic qualifications for ADHC personal care 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.

DMAS requirements may be met in one of the following ways:

- 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.

- 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 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.

- Training from an Educational/Medical Institution: Numerous hospitals, nursing facilities, and educational institutions provide nursing assistant training that is not Board of Nursing-approved (e.g., out-of-state curricula). This type of nursing assistant training is acceptable to meet DMAS requirements for personal care aides. Providers must obtain documentation from the educational or medical institution confirming the personal care aide successfully completed the course. This must be done prior to offering employment for Medicaid-reimbursed services.

- Provider-Offered Training: A provider may develop and offer a 40 hour training program incorporating all the following elements:

    - Goals of Personal Care, Prevention of Skin Breakdown, Physical and Biological Aspects of Aging, Physical and Emotional Needs of Older Adults, Physical Disabilities, Personal Care and Rehabilitative Services, Body Mechanics, Safety and Accident Prevention, Policies and Procedures Regarding Accidents and Injuries, Food Nutrition, and Meal Accommodation, Care of Personal Belongings, Documentation Requirements for Medicaid Individuals.

    - This training must be conducted by a registered nurse who meets the RN staffing requirements for personal care/respite providers. ALL graduates from the 40-hour provider training program must have a certificate of completion with the RN instructor's signature, printed name, and date of course completion.

    - Completion of the VADSA (Virginia Adult Day Services Association) Aide Note: An aide who has completed the VADSA training does not meet the qualifications as an aide for in-home personal/respite care services.

    - 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:
      The National Adult Day Services Association
      11350 Random Hills Road, Suite 800
      Fairfax, VA 22030 Email: info@nadsa.org
      memberservices@nadsa.org Phone: 1-877-745-1440

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to individuals receiving ADHC services. 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 individuals.

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 the aide has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable.

Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The personal care aide must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. 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 or has a founded complaint confirmed by the CPS Central Registry. The provider must have documentation proving that a criminal background check and central registry check if applicable was obtained. This documentation must be made available to DMAS staff or its contractors, upon request.

Providers shall obtain references from the educational facility, vocational school, or institution where the aide's training was received, if possible. 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 or its contractors.

Registered Nurse (RN)

The RN must:

- Be registered and currently licensed to practice nursing in the Commonwealth of Virginia;
- Have one year 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
- The RN must have a satisfactory work history as evidenced by documentation of two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single

employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is be acceptable.

Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks and crimes against minors obtained through the Virginia State Police. 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 or has a founded complaint confirmed by the CPS Central Registry.

Documentation of both license and clinical experience must be maintained in the provider's personnel file for review by DMAS staff or its contractors. A copy of the RN's current license must be in the personnel record.

Director

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

Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The Director must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. 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 or has a founded complaint confirmed by the CPS Central Registry.

Activities Director

The Activities Director must 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; and one year of related experience, which may include work in an acute care hospital, rehabilitation hospital or nursing home, or have completed a course of study including the prescribed internship in occupation, physical, or recreational therapy or music, dance, art therapy or physical education.

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

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. All PERS providers must enroll as DME providers in order to provide this service to Medicaid individual 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.

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.

PERS and Medication Monitoring services are designed to prevent or reduce inappropriate institutional care by providing eligible individuals 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 CCC Plus Waiver. The provider will be reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). 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.

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

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

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 individual's PERS equipment.

The monitoring agency's equipment must include the following: a primary receiver and a back-up receiver, 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 individual'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.

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.

PARTICIPATION SERVICES FACILITATION (SF) PROVIDER

A participating Consumer-Directed (CD) Services 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.

Services facilitation agencies provide supportive services designed to prevent or reduce inappropriate institutional care by offering assistance to eligible waiver individuals for the hiring, training, supervising, and firing responsibilities of the CD attendants, who perform basic health-related services. This chapter specifies the requirements for approval to participate as a Medicaid provider of services facilitation services. The services facilitation provider will be reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). 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 PARTICIPATION STANDARDS FOR SERVICES FACILITATION

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

CD Services Facilitator (SF) Requirements

SFs employed after January 11, 2016 shall have at least two references from prior job experience in direct care of the elderly or individuals with disabilities with no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children. If the SF has only worked for one employer, the SF must have a reference from the prior employer and an appropriate personal reference with no evidence of abuse, neglect, or exploitation. The SF must be 18 years of age or older. The SF must possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults.

All SFs shall complete required training and competency assessments with a score of 80% prior to working as a SF and must complete the competency assessments within every five years thereafter. Satisfactory competency assessment results shall be kept in the service facilitator's record. The training and competency assessment can be accessed through the DMAS website.

All SFs must possess the following knowledge, skills, and abilities:

Knowledge of:

- Types of functional limitations and health problems that may occur in older adults or individuals with disabilities, as well as strategies to reduce limitations and health problems;

- Physical assistance typically required by people who have physical disabilities or older adults, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

- Equipment and environmental modifications that are commonly used and required by people who have physical disabilities or older adults which reduce the need for human assistance and improve safety;

- Various long-term services and supports program requirements, including nursing facility level of care criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance and respite services;

- DMAS consumer-directed personal care attendant and respite services program requirements, as well as the administrative duties for which the individual will be responsible;

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

- Interviewing techniques;

- The waiver individual's right to make decisions about, direct the provision of, and control his or her services, including hiring, training, managing, approving work shifts, and firing a personal care aide;

- The principles of human behavior and interpersonal relationships; and

- General principles of record documentation.

Skills in:

- Negotiating with individuals and service providers;

- Assessing, supporting observing, recording, and reporting behaviors;

- Identifying, developing, and providing services to individuals who have disabilities or older adults; and

- Identifying services within the established services system to meet the individual's needs.

Ability to:

- Report findings of the assessment or onsite visit, either in writing or in an alternative format for persons who have visual impairments;

- Demonstrate a positive regard for individuals and their families;

- Be persistent and remain objective;

- Work independently, performing position duties under general supervision;

- Communicate effectively both orally and in writing; and
- Develop a rapport and communicate with individuals from diverse cultural backgrounds.

Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The SF must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. 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 or has a founded complaint confirmed by the CPS Central Registry.

If the services facilitator is not an RN, then the services facilitator shall inform the primary

health care provider for the individual who is enrolled in the waiver that services are being provided within 30 days from the start of such services and request consultation with the primary health care provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary health care provider. The documentation of this written permission to contact the primary health care provider shall be retained in the individual's medical record. All contacts with the primary health care provider shall be documented in the individual's medical record.

Services Facilitation providers cannot be spouses, parents (natural, step-parent, adoptive parent, foster parent, legal guardian), or any family member living under the same roof as the individual requesting services.

CONSUMER DIRECTED (CD) PERSONAL CARE ATTENDANT REQUIREMENTS

It is the individual's or their chosen Employer of Record (EOR) individual's responsibility to hire, train, supervise, and, if necessary, fire the personal care attendant. The EOR is considered the employer and can be the waiver individual or someone chosen by the individual to represent them. Each personal care attendant hired by the EOR/individual must be evaluated by the EOR/individual to ensure compliance with the minimum qualifications as required by DMAS.

Basic qualifications for personal care attendants include:

- 18 years of age or older;
- Ability to read and write in English to the degree necessary to perform the expected tasks and possess basic math skills;
- Have the required skills to perform care as specified in the individual's Plan of Care;
- Have a valid Social Security Number;
- Submitting to a criminal history record check and a child protective services central registry check for attendants that provide services care for minor children. The personal care attendant will not be compensated for services provided to the individual once the records check verifies the personal care attendant has been convicted of any of the crimes that are described in § 32.1-162.9:1 .
- Attend or receive training at the EOR's/individual's/family's request; and
- Understand and agree to comply with the consumer-directed personal/respite services requirements.

Payment may be made for services rendered by family members or caregivers living under the same roof as the individual receiving waiver services only when there is written, objective documentation as to why no other attendant is able to provide services for the individual. The family member or caregiver providing personal care services must meet the same requirements as other personal care attendants. This documentation is not required for a legally responsible individual (natural, adoptive, or foster parent; stepparent; or legal guardian of a minor under the age of 18 or a spouse).

Personal care attendants are prohibited from also serving as the EOR for the individual receiving waiver services.

No personal care attendant may work more than 16 hours in a day, starting at 12AM and ending at 11:59PM, providing Medicaid-reimbursed personal care and/or respite services.

SFs are not directly responsible for finding personal care attendants for the individuals; however, they are required to support the individual by providing hiring resources. SFs are also not responsible for verifying personal care attendants' qualifications; this is the responsibility of the EOR.

ASSISTIVE TECHNOLOGY (AT) and ENVIRONMENTAL MODIFICATION (EM) PROVIDER QUALIFICATIONS

AT and EM providers must be a durable medical equipment (DME) provider enrolled with DMAS in order to bill for these services for a waiver individual.

Providers of AT and EM services cannot be spouses, parents (natural, step-parent, adoptive parent, foster parent, legal guardian), or any family member living under the same roof as the individual requesting services.

Providers who supply AT and EM to waiver individuals shall not perform assessments/consultations or write AT or EM specifications for such individuals.

Providers who supply AT or EM for a waiver individual may not perform design or inspect AT or EM.

ANNUAL LEVEL OF CARE REVIEWS

DMAS will conduct annual level-of-care (LOC) reviews of each individual according to established procedures described in Appendix F of this manual.

If during an annual level of care review, it is determined that an individual who is using consumer-directed services no longer meets the established criteria for waiver services, the SF must inform the individual and EOR. It is the responsibility of the individual and EOR to ensure that the personal care attendants are made aware that the individual no

longer meets the level of care criteria to be eligible for CCC Plus waiver services. Payment to attendants on behalf of individuals who no longer meet criteria for waiver services will not continue and any additional payments will be the responsibility of the individual/EOR. The notification from the SF must be made in writing to the individual/EOR within 10 days (plus 3 days for mailing) of receipt of official notification by DMAS.

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

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

The statement of individual rights must include the following:

- The provider's responsibility to notify the individual in writing of any action taken which affects the individual's services;
- The provider's responsibility to render services according to acceptable standards of care;
- The provider's procedures for patient pay collection;
- The individual'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 individual when unable to provide care;
- The provider must inform the individual 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 individual should contact regarding schedule changes;
- The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the individual about his or her satisfaction with the services being rendered;
- Offer the individual choice of provider agencies and waiver services;
- The individual responsibility to notify the appropriate provider staff whenever the individual's schedule changes or assigned staff fail to appear for work; and
- The individual's responsibility to treat provider staff with respect and to

communicate problems immediately to the appropriate provider staff.

- The Individual'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, Services 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, if you are a CCC Plus member, you may contact your Health Plan Care Coordinator to assist you. For fee for service (FFS) members, you may contact the DMAS Office of Community Living by e- mail at cccpluswaiver@dmas.virginia.gov or the DMAS Recipient Helpline by calling 1-804-786-6145, or by mail at the following address:

DMAS
Office of Community Living 600 East Broad Street, Suite 1300
Richmond, VA 23219

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 individuals after the date specified in the termination notice.