CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider is an agency or program 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.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid individuals. Providers must sign the Mental Health, Mental Retardation and Substance Abuse Services Participation Agreement to provide Targeted Mental Retardation/Intellectual Disability (MR/ID) Case Management or the Mental Retardation Waiver Services Participation Agreement to provide any of the MR/ID Waiver services. (See the DMAS website at **www.virginiamedicaid.dmas.virginia.gov** to obtain forms.) This must be returned with a copy of the required license, certification or approval, as appropriate, to Xerox - Provider Enrollment Services.

Xerox - Provider Enrollment Services is the DMAS contractor responsible for provider enrollment. Xerox - Provider Enrollment Services will review the documentation from the provider that verifies provider qualifications. If the provider meets the qualifications as outlined in this chapter, Xerox - Provider Enrollment Services will send the provider notification that the application has been approved. The provider must maintain documentation (including relevant license, vendor agreement, letter of approval, personnel records, etc.) that verifies the provider's qualifications for review by DMAS and Department of Behavioral Health and Developmental Services (DBHDS) staff.

Upon the receipt of the signed contract, and the approval with signature by DMAS, a ten-digit Atypical Provider Identifier (API) number will be assigned as the provider identification number to each provider category (i.e., case management, private duty nursing, and personal/respite care). The provider will be sent a copy of the provider agreement and the assigned provider identification number. **DMAS will not reimburse the provider for any services rendered prior to the assigning of this provider identification number to your file.** This number must be used on all billing invoices and correspondence submitted to DMAS or Xerox – Provider Enrollment Services.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of MR/ID Community Services, the provider must:

1. Request the appropriate participation agreement from Xerox - Provider Enrollment Services by writing, telephoning, or faxing:

   Virginia Medicaid -PES
   PO Box 26803
   Richmond, Virginia 23261-6803

   804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

2. Forward a signed copy of the participation agreement with a copy of the required license, certification, or approval to:

   Virginia Medicaid -PES
   PO Box 26803
   Richmond, Virginia 23261-6803

   804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their participation agreements. Providers approved for participation in the Medicaid Program must perform the following activities, as well as any others specified by DMAS:

- Immediately notify Xerox - Provider Enrollment Services, DBHDS, and DMAS in writing, whenever there is a change in the information which the provider previously submitted to the Xerox - Provider Enrollment Services. For a change of address, notify Xerox - Provider Enrollment Services prior to the change and include the effective date of the change;

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;

- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to Medicaid individuals of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency .....…" The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse or a responsible relative;

- Providers may not bill DMAS or individuals for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid individuals;

- Use Medicaid Program-designated billing forms for submission of charges;

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope and details of the care 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. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years;

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

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of services to Medicaid individuals;
- Hold information regarding individuals confidential. 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 or DBHDS. DMAS and DBHDS shall not disclose medical information to the public, except as required by applicable law;

- Change of Ownership. When ownership of the provider agency changes, notify DMAS at least 15 calendar days before the date of change;

- All facilities covered by § 1616(e) of the *Social Security Act* in which home- and community-based care services will be provided shall in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DBHDS' licensure standards, 12 VAC 35-102-10 et seq. or through DSS approved standards for adult foster care providers and licensure standards 22 VAC 40-70-10 et seq.;

- Suspected Abuse or Neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the *Code of Virginia*, if a participating provider knows or suspects that a home- and community-based services individual is being abused, neglected, or exploited, or is at risk of such, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local department of social services in the locality where the individual resides or to the toll-free, statewide hotline number as posted on the Department of Social Services' website at **www.dss.virginia.gov** and to DBHDS; and

- Adhere to provider contract and the DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider contracts and in the DMAS provider manual.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

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

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician 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 Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet 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 Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the 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. See below for information on how to search the LEIE database.

3. 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, Ste 1300
Richmond, VA 23219
-or-
E-mailed to: **providerexclusions@dmas.virginia.gov**

PROVIDER QUALIFICATIONS

To qualify as a DMAS provider of selected MR/ID services, the provider of the services must meet the following criteria:

- The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

- The provider must have the administrative and financial management capacity to meet state and federal requirements; and

- The provider must have the ability to document and maintain individual records in accordance with State and federal requirements.

In addition to Targeted MR/ID Case Management that is provided to all MR/ID Waiver individuals, the MR/ID Waiver offers the following services:

- Assistive technology;
- Companion services (agency-directed and consumer-directed);
- Congregate residential support services;
- Crisis stabilization/supervision;
- Day support;
- Environmental modifications;
- In-home residential support;
- Personal assistance (agency-directed and consumer-directed);
- Personal emergency response systems (PERS);
- Prevocational services;
- Respite (agency-directed and consumer-directed);
- Service Facilitation
- Skilled nursing;
- Supported employment;
- Therapeutic consultation; and
- Transition services.

Providers of Day Support (DS) Services must meet the provider qualifications in this chapter. The DS Waiver offers:

- Day support services;
- Prevocational services; and
- Supported employment services

<u>Targeted MR/ID Case Management</u>

MR/ID Targeted Case Management providers must be licensed by DBHDS as a provider of case management services and operate a 24-hour emergency services system available for individuals.

A Mental Health and Mental Retardation Community Services Board (CSB) Participation Agreement to provider MR/ID Targeted Case Management must be obtained by the CSB or Behavioral Health Authority (BHA) from DMAS. The CSB/BHA may directly operate MR/ID Targeted Case Management Services or may contract with private agencies. If services are

contracted, the CSB/BHA remains the responsible provider, and only the CSB/BHA may bill DMAS for Medicaid reimbursement.

An employee of a CSB/BHA or provider, who providers MR/ID Targeted Case Management services, must possess a combination of MR/ID work experience and relevant education that indicates that he or she has the knowledge, skills, and abilities (KSAs) as established by DBHDS.

A person providing MR/ID Targeted Case Management Services is not required to be a member of an organization unit that provides only case management services. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, provide services as defined for MR/ID Targeted Case Management services, and comply with service expectations and documentation requirements as required for organized case management units.

A case manager may not be the direct support staff, the immediate supervisor of a direct support staff or the CD services facilitator (SF) to an individual for whom he or she is providing case management services.

Assistive Technology

Only a CSB/BHA or a DME provider may bill for this service. In cases where a CSB's/BHA's participation agreement does not include assistive technology, the CSB/BHA must expand its Mental Retardation Waiver Services Participation Agreement to provide assistive technology.

DMAS contracts directly with DME providers, which routinely provide specialized medical equipment and supplies in accordance with the Virginia State Plan for Medical Assistance. Equipment or supplies not covered by the State Plan may be purchased under MR/ID Waiver assistive technology.

Companion Services (Agency-Directed)

A provider must have a current DMAS Participation Agreement to provide companion services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The following types of providers can deliver companion services:

1. Licensed by DBHDS as a provider of residential services, supportive residential services, day support, or respite services; or

2. DMAS-enrolled personal care/respite provider.

Providers that provide companion services must employ individuals who meet the following requirements:

1. Are 18 years of age or older and possess a valid Social Security Number;
2. Are able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;
3. Have the required skills to perform services as specified in the individuals' service plan with minimal supervision;
4. Are capable of following a Plan for Supports with minimal supervision;
5. Submit to criminal history record check within 15 days from the date of employment. The companion will not be compensated for services provided to the individual subsequent to the receipt of a records check verifying that the companion has been convicted of crimes according to the requirements of the *Code of Virginia*, as applicable;
6. Receive an annual tuberculosis (TB) screening; and
7. Are capable of aiding the individual in the instrumental activities of daily living.

For the agency-directed model, companions must be employees of providers that contract with DMAS to provide companion services. Providers are required to have a companion supervisor to monitor companion services. The supervisor must have a bachelor's degree in a human services field and at least one year of experience working in the MR/ID field, or be ~~an~~ a registered nurse (RN) or a licensed practical nurse (LPN) with at least one year of experience working in the MR/ID field. An RN or LPN must have a current license issued by the Virginia Board of Nursing or a current multistate licensure privilege to practice nursing in the Commonwealth as a RN or LPN, as applicable.

Companions may not be individuals' spouses. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the supports; this must be approved and documented by the case manager. Family members who provide companion services must meet the same standards as providers who are unrelated to the individual.

Crisis Stabilization/Crisis Supervision

A Mental Retardation Waiver Services Participation Agreement to provide crisis stabilization for clinical services or crisis supervision for direct supervision services must be obtained from

Xerox - Provider Enrollment Services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

A crisis stabilization clinical or behavioral intervention services provider must be licensed by DBHDS as a provider of outpatient services, residential services, supportive residential services, or day support services.

In addition to meeting the above licensing requirements, the clinical services provider must employ or utilize qualified mental retardation professionals (QMRPs), licensed mental health professionals, or other personnel competent to provide clinical or behavioral interventions. These might include crisis counseling, behavioral consultation, or related activities to individuals with MR/ID who are experiencing serious psychiatric or behavioral problems. The face-to-face assessment or reassessment required to initiate or continue this service must be conducted by a QMRP.

The QMRP providing crisis stabilization services must have:

1. At least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities;

2. A bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; or a bachelor's degree in another field in addition to an advanced degree in a human services field; and

3. The required Virginia or national license, registration, or certification, as is applicable, in accordance with his or her profession.

To provide the crisis supervision component, providers must be licensed by DBHDS as providers of residential, supportive residential services, or day support services.

Day Support Services

A Mental Retardation Waiver Services Participation Agreement to provide day support services must be obtained from Xerox - Provider Enrollment Services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Day support providers must be licensed by DBHDS as a provider of day support services.

Providers must also assure that persons providing day support services have received training in the characteristics of MR/ID and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations prior to providing MR/ID Waiver direct

care services. This shall be accomplished through the *Staff Orientation Workbook* or the College of Direct Support (CDS). See the DBHDS website at **www.dbhds.virginia.gov/ODS-Training.htm#mr3** for more details about approved training options.

Environmental Modifications

Only CSB/BHA or durable medical equipment (DME) providers may bill for Medicaid reimbursement for environmental modifications provided by individuals or companies contracted by the CSB/BHA to make the necessary modifications. Therefore, in cases where a CSB's/BHA's participation agreement does not include environmental modifications, the CSB/BHA must expand its Mental Retardation Waiver Services Participation Agreement to include environmental modifications. The contractor must:

1. Comply with all applicable state and local building codes, with accommodations to meet the individual's needs (code variations permitted in individuals' residences, excluding group homes);

2. If used previously by the CSB/BHA, have satisfactorily completed previous environmental modifications; and

3. Be available for any service or repair of the environmental modifications.

It is possible that the services of any or all of the following three professions may be required to complete one environmental modification:

1. A Rehabilitation Engineer;

2. A building contractor; or

3. A vendor who supplies the necessary materials.

Personal Assistance Services (Agency-Directed)

A Mental Retardation Waiver Services Participation Agreement to provide personal assistance services must be obtained from Xerox – Provider Enrollment Services, except for those providers that have a DMAS Participation Agreement to provide personal care services. DMAS-enrolled personal care providers may provide MR/ID Waiver personal assistance under that agreement. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The following types of providers can deliver personal assistance services:

1. A provider licensed by DBHDS as a provider of residential services or supportive residential services. These providers must employ a program (residential services) supervisor who will provide ongoing supervision of all personal assistants and conduct the initial assessment and subsequent reassessments; or

2. Personal care/respite providers who have a participation agreement with DMAS. These providers (other than DBHDS-licensed providers) must:

   a. Employ or subcontract with and directly supervise a RN or LPN who will provide ongoing supervision of all personal assistants. RNs must conduct the initial assessment and subsequent reassessments;

   b. Ensure that the supervising RN or LPN has a current license issued by the Virginia Board of Nursing or a current multistate licensure privilege to practice nursing in the Commonwealth as an RN or LPN, as applicable, and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, ICF/MR, or nursing facility;

   c. Employ and directly supervise personal assistants who will provide direct support to individuals. Each assistant hired by the provider shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS. Each personal assistant must:

      (1) Be 18 years of age or older and possess a valid Social Security Number;

      (2) Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;

      (3) Have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

      (4) Have the required skills to perform services as specified in the individuals' service plan with minimal supervision.

   d. Ensure that assistants complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements.

      DMAS requirements for assistants may be met in one of three ways:

(1) Registration as a certified nurse aide (CNA);

(2) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant, or home health aide; or

(3) Completion of provider-offered training, which is consistent with the basic course outline consistent with the basic curriculum approved by DMAS that is found on the DMAS website at **http://www.dmas.virginia.gov/ltc-home.htm**. In addition, approved training schools, agencies, and other identities are available on the website.

e. Assistants must have a satisfactory work record, as evidenced by two references for prior job experiences, including no evidence of possible abuse, neglect, or exploitation of elderly or incapacitated adults or children.

Providers must also assure that persons providing personal assistance services have received training in the characteristics of MR/ID and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations prior to providing MR/ID Waiver direct care services. This shall be accomplished through the *Staff Orientation Workbook* or the College of Direct Support (CDS). See the DBHDS website at **www.dbhds.virginia.gov/ODS-Training.htm#mr3** for more details about approved training options.

DMAS will not contract directly with individuals to provide personal assistance services. Private agencies or CSBs/BHAs may employ or contract with individuals who meet the requirements to provide personal assistance services, but must then have a Provider Agreement with DMAS to provide personal assistance services and bill for the services provided by those individuals.

Personal assistance service providers may not be the parents of individuals who are minors or the individuals' spouses. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the supports; this must be approved and documented by the case manager. Family members who provide personal assistance services must meet the same standards as providers who are unrelated to the individual.

Personal Emergency Response System (PERS)

A PERS provider shall be a certified home health or personal care provider, a DME provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services, (including installation, equipment maintenance and service calls), and PERS monitoring. The

provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The PERS provider must provide an emergency response center staff with fully trained operators that 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 individual needs emergency help.

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

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

Prevocational Services

A Mental Retardation Waiver Services Participation Agreement to provide prevocational services must be obtained from Xerox – Provider Enrollment Services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers of prevocational services must be either:

1. A vendor of extended employment services, long-term employment support services, or supported employment services for the Department of Rehabilitative Services (DRS); or

2. Be licensed by DBHDS as a provider of day support services.

Providers must also assure that persons providing prevocational services have received training in the characteristics of MR/ID and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations prior to providing MR/ID Waiver direct care services. This shall be accomplished through the *Staff Orientation Workbook* or the College of Direct Support (CDS). See the DBHDS website at **www.dbhds.virginia.gov/ODS-Training.htm#mr3** for more details about approved training options.

Residential Support

A Mental Retardation Waiver Services Participation Agreement to provide residential support services must be obtained from Xerox – Provider Enrollment Services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Residential support services are only available in the MR/ID Waiver.

Residential Support providers for adults (age 18 years and older) must meet one of the following provider categories:

1. An agency licensed by DBHDS as a provider of residential services (group home or supervised residential) which may provide and bill for congregate residential support services or, in some cases, in-home support services when the DBHDS Office of Licensing has approved the provider under their residential license to provide less than 24-hour care in supervised apartments or other Office of Licensing approved settings (e.g., a provider operates supervised apartments under its residential services license and, with the agreement of Office of Licensing staff, provides less than 24-hour care to an individual in one of the apartments, but when services are rendered they are one-to-one with this individual. The provider may bill for-in-home support.);

2. An agency licensed by DBHDS as a provider of supportive residential services which may provide and bill for in-home support services or in some cases, congregate residential support when the provider goes into the home (not a group home) to provide services simultaneously to more than one individual living in that home (e.g., a provider operates a supported living apartment, under its supportive residential services license, in which two individuals reside. One staff person per shift assists both individuals simultaneously with activities of daily living and community access per their Plans for Supports (see Chapter IV for more information). This provider may bill congregate residential support for these two individuals.)

3. An agency licensed by DBHDS as a provider of sponsored residential home services that may provide and bill for congregate residential support services; or

4. A provider approved by the local DSS as an adult foster care (AFC) provider, using regulations promulgated by DSS that may provide and bill for congregate residential supports.

Residential support providers for children (under age 18 years) must meet one of the following provider categories:

1. An agency licensed by DBHDS as a provider of supportive residential services which may provide and bill for in-home supports or, in some cases, congregate residential support when the provider goes into the home (not a group home) to provide services simultaneously to more than one individual living in that home (e.g., a family has two children both receiving MR/ID Waiver residential services in the family home. The supportive residential services provider that is serving both children simultaneously may bill for congregate residential support); or

2. An agency licensed by DBHDS with ~~an~~ a Children's Residential Services License, which may provide and bill for congregate residential supports.

Providers must also assure that persons providing residential support have received training in the characteristics of MR/ID and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations prior to providing MR/ID Waiver direct care services. This shall be accomplished through the *Staff Orientation Workbook* or the College of Direct Support (CDS). See the DBHDS website at **www.dbhds.virginia.gov/ODS-Training.htm#mr3** for more details about approved training options.

Private providers or a CSB/BHA may employ or contract with individuals who meet the requirements to provide residential support, but the provider or CSB/BHA must have a provider agreement with DMAS to provide residential support and bill for the services provided by those individuals.

Residential support providers may not be the parents of individuals who are minors or the individual's spouses. Payment may not be made for services rendered by other family members who live under the same roof as the individual receiving services, unless there is objective written documentation as to why there are no other providers available to provide the supports; this must be approved and documented by the case manager. Family members who provide residential support services must meet the same standards as providers who are unrelated to the individual.

Respite Care Services (Agency-Directed)

A Mental Retardation Waiver Services Participation Agreement to provide respite services must be obtained from DMAS. Providers that have a DMAS Participation Agreement to provide respite services may provide MR/ID Waiver respite services under this agreement. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Any of the following types of providers can provide respite care services:

1. As defined in 12VAC35-102-10, a provider licensed by DBHDS as a provider of :

a. Supportive residential services, which may provide respite care services based in and from the individual's home;

b. Center-based respite services, which may provide respite services based in and from the approved respite center (licensed facility);

c. In-home respite services, which may provide respite services based in and from the individual's home;

d. Out-of-home respite care services, which may provide respite services based in and from the provider's home; or

e. Residential services, which may provide respite services based in and from the currently licensed group home, as long as the residential respite services are approved by DBHDS Office of Licensing;

2. A provider approved by DSS as a foster care home for children, which may provide respite services based from the provider's home to children only; or

3. A personal care/respite provider currently enrolled with DMAS to provide respite services, which may provide MR/ID Waiver respite services based in and from the home of the individual.

Respite services shall not be provided to relieve group home or assisted living facility staff where residential care is provided in shifts. Respite services shall not be provided by adult foster care providers for an individual residing in that home.

Personal care/respite providers who have a participation agreement with DMAS (other than DBHDS-licensed providers or adult foster home providers approved by DSS) must:

1. Employ or subcontract with and directly supervise a RN or LPN who will provide ongoing supervision of all personal assistants. The nurse must conduct the initial assessment and subsequent reassessments;

2. Ensure that the supervising RN or LPN has at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/MR, or NF. The RN or LPN must have a current license issued by the Virginia Board of Nursing or a current multistate licensure privilege to practice nursing in the Commonwealth as a RN or LPN, as applicable;

3. Employ and directly supervise respite assistants who will provide direct support to individuals. Each assistant hired by the provider shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS; and

4. Based on continuing evaluations of the assistant's performance and individual's needs, the nurse supervisor shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

If the provider is a DBHDS-licensed or DSS-approved provider, a (residential) supervisor will provide ongoing supervision of all respite assistants.

Each assistant must meet the following requirements:

1. Be 18 years of age or older and possess a valid Social Security Number;

2. Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;

3. Have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

4. Have the required skills to perform services as specified in the individuals' service plan with minimal supervision.

Respite assistants employed by DMAS Personal Care/Respite providers must complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements for assistants may be met in one of three ways:

1. Registration as a certified nurse aide (CNA);

2. Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant, or home health aide; or

3. Completion of provider-offered training, which is consistent with the basic course outline consistent with the basic curriculum approved by DMAS that is found on the DMAS website at **http://www.dmas.virginia.gov/ltc-home.htm**. In addition, approved training schools, agencies, and other identities are available on the website.

Respite assistants may not be the parents of individuals who are minors or the individuals' spouses. Payments may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written

documentation as to why there are no other providers available to provide the supports; this must be approved and documented by the case manager. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

Skilled Nursing Services

A Mental Retardation Waiver Services Participation Agreement to provide Skilled Nursing services must be obtained from Xerox – Provider Enrollment Services. Providers that have a DMAS Participation Agreement to provide private duty nursing or home health services may provide MR/ID Waiver skilled nursing services under this agreement. The provider designated in the Participation Agreement is the responsible provider and must bill DMAS for Medicaid reimbursement.

The following types of providers can provide skilled nursing services:

1. A provider enrolled by DMAS as a home care organization or home health provider; or

2. A RN or LPN, under the supervision of a RN, contracted or employed by DBHDS licensed respite, day support, or residential support providers. The RN or LPN must have a current license issued by the Virginia Board of Nursing or a current multistate licensure privilege to practice nursing in the Commonwealth as an RN or LPN, as applicable.

Skilled nursing services providers may not be the parent of individuals who are minors or individual's spouses. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the supports; this must be approved and documented by the case manager. Family members who provide skilled nursing services must meet the same standards as providers who are unrelated to the individual.

A foster care provider may not be the nursing services provider for the same persons to whom they provide foster care. Private duty nursing services are not offered under this waiver.

Supported Employment Services

A Mental Retardation Waiver Services Participation Agreement to provide supported employment services must be obtained from Xerox – Provider Enrollment Services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Supported employment providers must be a vendor of supported employment services with DRS.

Therapeutic Consultation

A Mental Retardation Waiver Services Participation Agreement to provide therapeutic consultation services must be obtained from Xerox – Provider Enrollment Services. An individual consultant with the necessary qualifications may obtain a DMAS Participation Agreement or be employed by or contracted with a provider with a Participation Agreement to provide the services. The provider designated in the participation agreement must directly provide the services and bill DMAS for Medicaid reimbursement. Individuals with the necessary qualifications must provide a copy of their current Virginia license or certification, along with the completed Therapeutic Consultation application that is a part of the provider enrollment package.

The following types of therapeutic consultation are reimbursable as MR/ID Waiver services when the individual consultant or the employee of an agency with a valid Participation Agreement meets the required provider standard:

1. Psychology Consultation may be provided by an individual who is:

    - A psychiatrist who is licensed by the Commonwealth of Virginia;
    - A psychologist who is licensed by the Commonwealth of Virginia;
    - A Licensed Professional Counselor (LPC) who is licensed by the Commonwealth of Virginia;
    - A Licensed Clinical Social Worker (LCSW) who is licensed by the Commonwealth of Virginia; or
    - A Psychiatric Clinical Nurse Specialist who is licensed by the Commonwealth of Virginia.

2. Behavior Consultation may be provided by an individual who:

    - Meets the above criteria to provide a psychology consultation; or
    - Is a Positive Behavioral Supports Facilitator endorsed by the Partnership for People with Disabilities at Virginia Commonwealth University; or
    - Is a board-certified Behavior Analyst (BCBA) or board-certified Associate Behavior Analyst (BCABA).

3. Speech Consultation: This service shall be provided by a speech-language pathologist who is licensed by the Commonwealth of Virginia.

4. Occupational Therapy Consultation: This service shall be provided by an occupational therapist who is certified by the Commonwealth of Virginia.

5. Physical Therapy Consultation: This service shall be provided by a physical therapist who is licensed by the Commonwealth of Virginia.

6. Therapeutic Recreation Consultation: This service shall be provided by a therapeutic recreational specialist who is certified by the National Council for Therapeutic Recreation Certification.

7. Rehabilitation Consultation: This service shall be provided by a certified rehabilitation engineer or certified rehabilitation specialist.

Consumer-Directed (CD) Services

Consumer-Directed Services Facilitation

Providers must have a current DMAS Participation Agreement to provide CD Services Facilitation services. To be enrolled as a Medicaid CD Services Facilitation provider and maintain provider status, the SF shall have sufficient resources to perform the required activities. In addition, the SF must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

It is preferred that the SF possess a minimum of an undergraduate degree in a human services field or be a RN currently licensed to practice in the Commonwealth. In addition, it is preferable that the SF have two years of satisfactory experience in the human services field working with persons with MR/ID. The SF shall possess a combination of work experience and relevant education, which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation or be observed during a job interview. Observations during an interview must be documented. The knowledge, skills, and abilities shall include, but not necessarily be limited to:

1. Knowledge of:

    a. Types of functional limitations and health problems that may occur in persons with MR/ID and other disabilities, as well as strategies to reduce limitations and health problems;

b. Physical assistance that may be required by people with -MR/ID, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

c. Equipment and environmental modifications that may be used by people with MR/ID which reduces the need for human help and improves safety;

d. Various long-term care program requirements, including nursing facility and ICF/MR placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;

e. MR/ID Waiver requirements, as well as the administrative duties for which the individual will be responsible;

f. Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;

g. Interviewing techniques;

h. The individual's right to make decisions about, direct the provisions of, and control his personal assistance, respite and companion services, including hiring, training, managing, approving time sheets, and firing an assistant or companion;

i. The principles of human behavior and interpersonal relationships; and

j. General principles of record documentation.

2. Skills in:

a. Negotiating with individuals and service providers;

b. Assessing, supporting, observing, recording, and reporting behaviors;

c. Identifying, developing, or providing services to persons with MR/ID; and

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

3. Abilities to:

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

b. Demonstrate a positive regard for individuals and their families;

c. Be persistent and remain objective;

d. Work independently, performing position duties under general supervision;

e. Communicate effectively, verbally and in writing; and

f. Develop a rapport and communicate with persons from diverse cultural backgrounds.

If the SF is not a RN, the SF must contact the primary health care provider to inform him or her that services are being provided and to request consultation as needed regarding the health needs of the individual. MR/ID Waiver skilled nursing consultation is also available as needed for this purpose. This requirement does not involve an actual visit to the health care provider and is not meant to replace appropriate physician's office visits.

The SF may not also be the case manager or direct service provider for a given individual. The SF may also not be the individual, the individual's parent if the individual is a minor, the individual's spouse, or the person acting as an employer on behalf of the individual.

Consumer-Directed Assistant and Companion Qualifications

For CD personal assistance, CD respite, and CD companion services, individuals will hire their own assistants/companions and manage and supervise the assistant's/companion's performance. If an individual is unable to direct his or her own services, a family member/caregiver may act on behalf of the individual as the employer of the assistant/companion.

Assistants/companions do not need to be enrolled with DMAS (i.e., have a participation agreement) to provide CD personal assistance, CD respite, or CD companion services.

Assistant/companion qualifications include but shall not necessarily be limited to the following requirements. The assistant/companion must:

- Be 18 years of age or older;
- Have the required skills to perform services as specified in the individual's ISP;
- Possess basic math, reading, and writing skills;
- Possess a valid Social Security number;

- Submit to a criminal records check and, if the individual, to whom the assistant/companion will be providing services, is a minor, consent to a search of the DSS CPS Central Registry. The assistant/companion will not be compensated for services provided to the individual subsequent to the receipt of a records check verifying that the assistant has been convicted of crimes described in the *Code of Virginia*, §37.2-416, or if the assistant/companion has a founded complaint confirmed by the CPS Central Registry;
- Be willing to attend training at the individual's or family member's/caregiver's request;
- Understand and agree to comply with the DMAS MR/ID Waiver requirements; and
- Agree to receive an annual tuberculosis (TB) screening.

CD assistants/companions shall not be individuals' spouses or parents of individuals who are minors. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the supports; this must be approved and documented by the case manager. Family members who provide CD services must meet the same standards as providers who are unrelated to the individual.

Additional information for individuals who choose the CD model of services and their family/caregivers, as applicable, may be found in the *Consumer-Directed Waiver Services Employer Manual* that is available on the DMAS website at **www.virginiamedicaid.dmas.virginia.gov** under "Long-Term Care and Waiver Services."

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, 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, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

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.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance 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) -** Virginia Medicaid will pay the amount of any deductible or coinsurance 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 Medicaid Program payments shall be made for a patient covered by Workers' Compensation.

- **Other Health Insurance -** When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the 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 Medicaid individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid 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 Medicaid.

- In the case of an accident in which there is a possibility of third-party liability or if the individual reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 to:

  Third-Party Liability Casualty Unit
  Virginia Medical Assistance Program
  600 East Broad Street
  Richmond, Virginia 23219

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid (either a termination of all Medicaid services or any one or more of several services being provided by the agency) at any time; however, written notification must be provided to the DMAS Director and Xerox-PES thirty (30) days prior to the effective date. The addresses are:

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

Virginia Medicaid -PES
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider from participating in the Medicaid program upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to individuals subsequent to the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

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

APPEALS OF ADVERSE ACTIONS

PROVIDER APPEALS

Non-State Operated Provider

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

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level Informal Appeal with the DMAS Appeals Division **within 30 calendar days** of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

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

If the provider is dissatisfied with the first-level Informal Appeal decision, the provider may file a written notice for a second-level appeal Formal Appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia,* § 2.2-4000 et seq. The notice for a second-level Formal Appeal must be filed **within 30 calendar days** of receipt of the first-level Informal Appeal decision. The notice for second-level Formal

Appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

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

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA), the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

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

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

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

Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325.1D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 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.

Repayment of Identified Overpayments

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

State-Operated Provider

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

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

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

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

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

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

CLIENT APPEALS

The Code of Federal Regulations at 42 CFR $43 1 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 11th floor
Richmond, Virginia 23219
Appeal requests may also be faxed to: (804) 371-8491

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are members of a group using one central office may receive multiple copies of updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing

a written request to the Xerox – Provider Enrollment Services at the address given under "Requests for Participation" earlier in this chapter.

All Medicaid provider manuals are available on-line on the DMAS website at **www.virginia medicaid.dmas.virginia.gov**.