Virginia Regulatory Town Hall

Final Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services; 12 VAC 30
VAC Chapter Number:	12 VAC 30-120
Regulation Title:	Elderly and Disabled Waiver
Action Title:	E&D Waiver
Date:	11/20/2002; **MUST HAVE GOV APPROVAL BY 12/10**

Please refer to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99) , and the *Virginia Register Form,Style and Procedure Manual* for more information and other materials required to be submitted in the final regulatory action package.

Summary

Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment; instead give a summary of the regulatory action. If applicable, generally describe the existing regulation. Do not restate the regulation or the purpose and intent of the regulation in the summary. Rather, alert the reader to all substantive matters or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. Please briefly and generally summarize any substantive changes made since the proposed action was published.

The current regulations for the Elderly and Disabled (E&D) Waiver program describe the criteria that must be met in order for providers to be reimbursed for the services rendered. The current services offered in this waiver include personal care, respite care, and adult day health care. The emergency regulations added the personal emergency response systems (PERS) to the waiver.

The changes to the regulations include the following: (1) addition of PERS as a permanent covered service; (2) addition of language regarding waiver desk reviews, which the Centers for Medicare and Medicaid Services (CMS) requires DMAS to perform; (3) addition of language referencing the *Code of Virginia* regarding criminal records checks for all compensated employees of personal care, respite care, and adult day health care agencies; (4) addition of language that states that personal care recipients may continue to work and attend post-secondary school while receiving services under this waiver; (5) change in the requirement of supervisory visits from every 30 days in general to every 30 days for recipients with a cognitive impairment,

and up to every 90 days for recipients who do not have a cognitive impairment; (6) addition of some 'family members' to the definition of who is qualified to perform personal care services; (7) addition of the required qualifications for LPNs for respite care; and (8) clarifications and corrections to the existing language.

Changes Made Since the Proposed Stage

Please detail any changes, other than strictly editorial changes, made to the text of the proposed regulation since its publication. Please provide citations of the sections of the proposed regulation that have been altered since the proposed stage and a statement of the purpose of each change.

VAC Citation	Proposed Regs	Final Regs	Rationale
12VAC30-120-10	Definitions	Some definitions were deleted, revised, or added for clarification of the regulations.	To clarify regulations.
12VAC30-120-20	General coverage and requirements for all home and community-based care waiver services	Additional information was added, deleted, or revised for clarification of the regulations.	To clarify regulations.
12VAC30-120-30	General conditions and requirements for all home and community-based care participating providers	Additional information was added, deleted, or revised for clarification of the regulations.	To clarify regulations.
12VAC30-120-40	Adult day health care services	Additional information was added, deleted, or revised for clarification of the regulations.	To clarify regulations.
12VAC30-120-50	Personal care services	Additional information was added, deleted, or revised for clarification of the regulations.	To clarify regulations.
12VAC30-120-55	Personal emergency response system services	Additional information was added for clarification of the regulations.	To clarify regulations.
12VAC30-120-60	Respite care services	Information was	To clarify regulations.

		deleted for clarification of the regulations.	

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency: including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended regulations 12 VAC 30-120-10 through 12 VAC 30-120-60, Elderly and Disabled Waiver, and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Basis

Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority, shall be provided. If the final text differs from that of the proposed, please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.

The Code of Virginia § 32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia §32.1-324 grants to the Director of DMAS the authority to administer and amend the Plan of Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code of Virginia also provides, in the Administrative Process Act (APA) §§ 2.2-4007 and 2.2-4012, for this agency's promulgation of proposed regulations subject to the Governor's review.

Subsequent to an emergency adoption action, the agency initiated the public notice and comment process as contained in the Article 2 of the APA. The emergency regulation became effective on February 1, 2002. The Code, at § 2.2-4007 requires the agency to file the Notice of Intended

Regulatory Action within 60 days of the effective date of the emergency regulation if it intends to promulgate a permanent replacement regulation. The Notice of Intended Regulatory Action for this regulation was filed with the Virginia Register on January 31, 2002.

Purpose

Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the final regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.

Previously, services under the E&D Waiver included personal care, respite care, and adult day health care services. The addition of the personal emergency response systems (PERS) allows individuals who are at risk of institutionalization to remain in their homes with less direct human supervision. PERS are electronic devices that enable community recipients to secure help in an emergency. PERS services are limited to those recipients who live alone or are alone for significant parts of the day with no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision by personal care aides.

This regulatory action is expected to help protect the health, safety, and welfare of participants in this waiver. These regulations will provide a service which enable recipients to live successfully in their homes and communities.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement of the regulatory action's detail.

The regulations affected by this action are the Elderly and Disabled Waiver regulations (12 VAC 30-120-10 through 12 VAC 30-120-60).

In March 2001, DMAS convened a workgroup to assist with the development of the waiver renewal application to CMS, the E&D Waiver Manual, and the corresponding regulations. The workgroup was comprised of staff from DMAS, other state agencies, provider agencies, provider associations, and consumers. In order to make the changes to the waiver program that the workgroup and DMAS agreed upon and to permanently add the new PERS services to the waiver, new permanent regulations are required. Without these regulations, DMAS will lack the regulatory authority to require the provider to adhere to the agreed upon changes.

Of those recipients receiving personal care services, approximately 10% require these services due to the need for supervision. Supervision is a covered service within the plan of care when its purpose is to supervise or monitor those recipients who require the physical presence of an aide

to ensure their safety during times when no other support system is available. The inclusion of supervision in the plan of care is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation.

For those recipients who are physically frail and impaired, PERS could greatly improve their autonomy and ability to remain in the community without requiring an aide's presence. Prior to the addition of the PERS service, recipients used personal care services to meet their supervision needs. If recipients who require supervision services use PERS instead of personal care services, more aides would be available to provide direct services to recipients who require personal care services, thus, delaying or preventing the institutionalization of those other recipients who require personal care services other than supervision only.

During the emergency regulatory review process, the Department of Planning and Budget (DPB) suggested two changes to DMAS when working on the proposed regulations. The first suggestion concerned the definition of the PERS. In the definition of PERS, the circumstances in which PERS is an appropriate service were also included. DPB suggested that the circumstances be moved out of the definition of the PERS service. DMAS changed this in the proposed regulations.

DPB's second suggestion concerned the following statement: "If the recipient's caregiver has a business in the home, such as a day care center, PERS will only be approved if the recipient is evaluated as being dependent in orientation and behavior pattern." DPB suggested that DMAS define the terms "dependent", "orientation", and "behavior pattern." DMAS clarified this requirement in the proposed regulations.

Issues

Please provide a statement identifying the issues associated with the final regulatory action. The term "issues" means: 1) the advantages and disadvantages to the public of implementing the new provisions; 2) the advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please include a sentence to that effect.

The primary advantage for the Commonwealth's citizens regarding the addition of PERS as a new covered service in the Elderly and Disabled Waiver is that it could greatly improve a recipient's autonomy and ability to remain in the community without requiring an aide's presence. It could enable some recipients to live on their own and enable some recipients to remain with their families, instead of being institutionalized. To the extent of their abilities, recipients will be able to function in their communities, attending school and continuing employment. Another advantage is that, since recipients who use personal care services for their supervision needs can use the PERS service, the personal care aides that will no longer have to provide the supervision services could provide the direct personal care services to recipients who require personal care services other than supervision only.

Changing the requirement of supervisory visits from every 30 days in general to every 90 days for non-cognitively impaired individuals will allow recipients more freedom and privacy in their homes. This change would not affect the quality of the care the recipients receive. This change would not affect those recipients with a cognitive impairment as the requirement for the supervisory visit remains at every 30 days. DMAS also included a safeguard in these regulations which states that if a recipient's personal care aide is supervised by the provider's registered nurse less often than every 30 days and DMAS determines that the recipient's health, safety and/or welfare is in jeopardy, DMAS or the designated preauthorization contractor, may require the provider's registered nurse to supervise the personal care aide every 30 days or more frequently.

All of the proposed changes to the regulations are intended to protect the recipient from abuse, to prevent the recipient from receiving services from unqualified staff, and to promote the recipient's independence in the community.

There are no disadvantages to the public or the Commonwealth with these regulation changes.

Public Comment

Please summarize all public comment received during the public comment period and provide the agency response. If no public comment was received, please include a statement indicating that fact.

SUMMARY OF PUBLIC COMMENTS

Home and Community Based Waiver for Elderly and Disabled Individuals

E and D Waiver

12VAC 30-120-10 through 12 VAC 30-120-60

DMAS' proposed regulations were published in the August 26, 2002, *Virginia Register* (18:25 p 3461 et seq.) for their comment period from August 26 through October 25, 2002. Comments were received from representatives of Health Watch, Inc., Disabled Action Committee, Virginia Poverty Law Center, the Department of Social Services Adult Services, and the Alzheimer's Association (via electronic mail).

A summary of the comments received follows:

Comment: The comments from Health Watch, Inc., detailed a very high level of monitoring of functional PERS units, their batteries, and other equipment, pointing out that this level of monitoring by this company was much higher than required in the proposed regulations. Health Watch urged DMAS to raise the monitoring standards to the highest level of service for the clients.

Agency Response: DMAS contacted two other providers of PERS services to obtain their opinion on whether the current emergency regulations and the recommend proposed regulations are adequate to ensure recipient health and safety. The responding PERS provider stated that the regulations are adequate to ensure recipients' health and safety. DMAS also believes that the regulations are sufficient to ensure recipient health and safety.

Comment: The comments from the Disabled Action Committee concerned several subjects.

1. This commenter stated that the inclusion of the coverage of PERS services was nice, but redundant to other services already available. This commenter also suggested using "drug rebate" monies for the PAS (personal assistance service) programs.

2. 12 VAC 30-120-30 gives the individual the right to "reconsideration" of his provider's decision to decrease his level of care. However, what is entailed in this "reconsideration" is not explained and there are no timeframes for such "reconsideration."

3. 12 VAC 30-120-30 also allows the personal care provider to terminate personal care services simply by sending a 5-day notification letter. No explanation of termination is required, no individual right to review or provision of benefits to the individual pending the review is provided for. Personal care providers should be required to give at least 3 weeks notice in order to prevent patient dumping when cases become heavy care or difficult.

4. 12 VAC 30-120-30 also allows personal care providers to terminate services in "emergency" situations without any notice at all. This should not be permitted.

5. 12 VAC 30-120-30 also allows DMAS to terminate community-based services with a 10-day notice and 3 specific reasons for termination are provided. However, individuals' appeal rights are not included. The proposed regulations also delete, without explanation, previous sections that had addressed provider requirements when unable to render services and aide substitutions. The deletion of provider responsibility to secure substitute aides and/or notify the individual and/or family leaves a huge hole in the regulations.

Agency Response: In response to #1, the addition of PERS to the E&D Waiver has made it possible for some recipients to receive PERS services when they were unable to receive this service before. The state share of funds received from drug rebates are either deposited in the Commonwealth's General Fund as prior year recoveries or classified as an expenditure reduction and used to decrease DMAS' current expenditures. In either case, all of the drug rebate funds are accounted for in the Commonwealth's budget and cannot be re-designated for another program without requiring reductions in other programs.

In response to #2, the regulations were changed to add that the recipient has the right to reconsideration by DMAS or the designated preauthorization contractor. In addition, the Client Appeals regulations are generally available in numerous places to all Medicaid recipients both in hard copy form and electronically. To duplicate the steps and timeframes of the Client

Appeals regulations in the Elderly and Disabled waiver regulations would create updating and maintenance problems for the agency and could result in DMAS promulgating conflicting regulations.

In response to #3, providers must be willing and able to provide services; providers have the right to decide to whom they will provide services. 12 VAC 30-120-30J3, states "Non-emergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient or family, or both, five days written notification of the intent to terminate services. The letter shall provide the reasons for and the effective date of the termination." Furthermore, providers under this waiver are required to comply with all applicable State and Federal laws, including but not limited to, the Rehabilitation Act of 1973, which limit a provider's ability to terminate care based on discrimination or other unlawful reasons. .

In response to #4, providers may terminate a recipient from services when the health and safety of the recipient or provider personnel is endangered. Although a five-day written notification period is not required, DMAS or the designated preauthorization contractor must be notified prior to actual termination. This is included in order to alert DMAS or the contractor to any potential situations where the recipient's health and safety may be endangered. DMAS has used this emergency prior notification requirement in other waiver programs and has found it adequately protects recipients. To prevent providers from protecting their personnel in dangerous situations would create liability problems for providers and might preclude their enrollment as Medicaid service providers.

In response to #5, this section of the regulations specifies that DMAS may terminate community-based services with a 10-day notice and four reasons are provided in the regulations. These four reasons constitute part of the criteria for home and community-based care services. If any of these reasons exist, home and community-based care services are not appropriate for a recipient and are to be terminated as federal financial participation is not available to the Commonwealth for such inappropriate placements.

Reconsideration information is already included in the Client Appeals regulations (12 VAC 30-110-10 et seq.) as well as in the provider manual. The proposed regulations delete sections related to the provider's inability to provide services and substitution of aides as this procedural information is contained in the provider manual.

Waiver recipients can access all provider manuals and the Client Appeals regulations via the DMAS website or can obtain hard copies merely by requesting them. To reiterate specific steps and timeframes for client appeal reconsiderations in these regulations would create updating and maintenance problems for the agency.

Comment: The comments from the Virginia Poverty Law Center concerned several subjects. The commenter supported the coverage of PERS services in this waiver program. Support was also given to allowing relatives, other than immediate family members who are excluded, to be reimbursed as the individual's personal care aide. Other comments included the following:

12 VAC 30-120-30, regarding "changes or termination of care" requires further changes and clarifications. Recipients' rights are not clearly set out in situations of changes of levels of care and/or terminations of community based services.

Reference is made to the recipient's right to "reconsideration" of the provider's decision to decrease the level of care but no description or explanation of the "reconsideration" process is provided.

Providers are permitted to terminate care with the simple issuance of a 5-day notification letter. No explanation is necessary for this termination to take effect. No right to review of this decision or the continuation of benefits pending the review is provided for. Individuals have been dumped in this manner.

This regulation section permits providers to terminate services in emergency situations without any written notice to the affected individuals or the individuals' right of review. Also, DMAS is permitted to terminate community-based services with a 10-day written notice but again this particular regulation section does not reference appeal rights.

> "By definition, all recipients of E&D Waiver services are at risk of institutionalization. The abrupt termination of community-based care services can be dangerous and perhaps life threatening to the individual. A provider should never be permitted to drop a patient without cause; and the individual must have an opportunity (in both emergency and non-emergency circumstances) to contest the basis for a proposed termination. Medicaid law and due process principles also generally require that services continue pending the outcome of any review requested."
>
> "The lack of clear regulatory requirements for notices and appeals has been problematic for individuals receiving community-based care. The regulations must be improved to incorporate these fundamental procedural protections for a very vulnerable population."
>
> This commenter went on to say that recipients of home and community-based care need reliable services as they are entirely dependent on their aides for even getting out of bed and daily hygiene. Service interruption can be dangerous. Providers, undertaking to provide such services, must bear the obligation to ensure continuity of care that may be caused by staff sickness or absences.

Agency Response: In response to #1 and #2, information was added to the regulations that states that the recipient has the right to reconsideration by DMAS or the designated preauthorization contractor. In addition, reconsideration information is also included in the Client Appeals regulations and provider manual and therefore is not duplicated here.

In response to #3, providers must be willing and able to provide services; providers have the right to decide to whom they will provide services. 12 VAC 30-120-30, J, 3, states "Non-emergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient or family, or both, five days written

notification of the intent to terminate services. The letter shall provide the reasons for and the effective date of the termination."

In response to #4, provider agencies may terminate a recipient from services when the health and safety of the recipient or provider agency personnel is endangered. Although a five-day written notification period is not required, DMAS or the designated preauthorization contractor must be notified prior to termination. This is included in order to alert DMAS or the contractor to any potential situations where the recipient's health and safety may be endangered. This section of the regulations specifies that DMAS may terminate home and community-based services with a 10-day written notice and four reasons are provided in the regulations. These four reasons constitute part of the criteria for home and community based care services. If any of these reasons exist, home and community-based care services are not appropriate for a recipient and therefore must be terminated as federal financial participation is not available for this recipient. Reconsideration information is included in the Client Appeals regulations (12 VAC 30-110-10 et seq.) as well as in the provider manual, as it is procedural information.

In response to #5, the proposed regulations also delete sections related to the provider's inability to provide services and substitution of aides. This information is contained in the provider manual. Since this is a procedure for providers, it is not appropriate to include it in the regulations.

Comment: The Department of Social Services, Adult Services Division comments supported the addition of the PERS service to this waiver program. Also, the proposed change of the Registered Nurse supervisory visit from every 30 days to every 90 days for recipients not having cognitive impairments was also supported.

Agency Response: DMAS appreciates the support from the Department of Social Services.

Comment: The Alzheimer's Association comments addressed 12 VAC 30-120-50, Personal Care Services, regarding the proposal to extend supervisory nursing visits to every 90 days for individuals not having a cognitive impairment. The commenter pointed out that persons with early and mid-stages of Alzheimer's disease may be able to reduce their observable cognitive loss (with treatment) sufficiently that they would not be considered impaired by the proposed definition. However, as the disease progresses, an individual with Alzheimer's continues to lose cognitive abilities until he is considered impaired.

Under the proposed regulations, many things can change for an Alzheimer's patient within the 90 days between supervisory nursing visits. Consequently, the proposed regulations do not adequately protect Alzheimer's patients. The commenter suggested that the definition of cognitive impairment be modified to include reference to probable or actual diagnosis of Alzheimer's disease or other dementia disorder.

Agency Response:

After extensive discussion by the previously mentioned workgroup, the definition of cognitive impairment was reached. Since the proposed definition expresses the intent of the entire group,

DMAS is not recommending changes at this time. However, should experience over time indicate that modifications should be considered, DMAS will reconsider this issue.

Detail of Changes

Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or crosswalk - of changes implemented by the proposed regulatory action. Include citations to the specific sections of an existing regulation being amended and explain the consequences of the changes.

The proposed regulations add a section to the Elderly and Disabled Waiver section of the Virginia Administrative Code for the PERS service (12VAC30-120-10 through 12VAC30-120-60).

12VAC30-120-10

- The definition of "designated preauthorization contractor" was added in order to define the term that was added throughout the regulations.
- The definition of "medication monitoring" was added to define this component of the PERS service.
- Definitions related to the PERS service were added.
- The definition of "Plan of Care" was changed to specify that the plan of care is developed by the provider related solely to the specific services required by the recipient.
- The definition of "Service Plan" was added to specify the plan that is developed and certified by the screening teams.
- The definition of "respite care" was changed to add the word "unpaid" when discussing the primary caregiver as the recipient of the respite services.

12VAC30-120-20

Language was added to clarify the preauthorization requirements that providers must follow in order to receive reimbursement from Medicaid. (subsection C 2)

Language was added to clarify that Medicaid will not pay for any services delivered prior to the authorization date approved by the screening team and the physician signature on the Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96). The DMAS-96 form is attached. Language was also added to clarify that if services have not begun within 6 months of

the screening, a new screening must be completed or an update to the original screening must be completed prior to the beginning of services. (subsections C 7)

12VAC30-120-30

Language was added to clarify that the recipient has the choice of providers if there is more than one participating provider who provides services in the recipient's community and that the recipients will have the option of selecting the provider of his choice from among those providers which can appropriately meet the recipient's needs. (subsection E)

Language was corrected in the section regarding termination of provider participation. The old language specified that DMAS may terminate a provider from participation upon 60 days' written notification. This was changed to 30 days per the regulations to be consistent with other DMAS regulations. (subsection F)

Language was corrected in the section regarding the time that the provider has to submit language for reconsideration, informal conference, and formal evidentiary hearing. The old language specified that the provider had 15 days to submit this information. In these proposed regulations, this language was corrected to specify 30 days, as per the appeals regulations. (subsection G 2)

Language was added for clarity regarding decreases in amount of authorized care by the provider. The new language specifies that the provider may decrease the amount of authorized care if the amount of care in the revised plan of care is appropriate based on the needs of the recipient. Language is also included that specifies what the recipient's appeals options are if he disagrees with this decrease. (subsection I 1 a)

Language currently states that the provider must discuss with the recipient or family or both the decrease in care and that the provider must notify the recipient or family of the change by letter. The new language states that this letter must give the right to reconsideration. (subsection I, 1, c)

New language was added which states that a provider's noncompliance with DMAS policies and procedures, as required in the provider's contract, may result in a retraction of Medicaid payment or termination of the provider agreement. (subsection K)

Language was added regarding waiver desk reviews. DMAS added this language per CMS' requirement that DMAS perform this function.

12VAC30-120-40

The current language states that the adult day health care (ADHC) center must provide a separate room or area equipped with one bed or cot for every six Medicaid participants. Language was added to allow recliners to count in this ratio and the ratio was changed to one for every twelve participants. (subsection B 3)

Language was added to be consistent with the DSS regulations for ADHCs regarding the use of volunteers. (subsection B 4, d)

Language was added to clarify the amount of time that a registered nurse must be present in the ADHC each month. The old language specified that the registered nurse must be present a minimum of one day each month at the ADHC. The new language specifies that the registered nurse must be present a minimum of eight hours each month at the ADHC. Language was deleted that required the registered nurse to render direct services to Medicaid adult day health care participants. (subsection B 4, g)

New language was added under the qualifications of the ADHC program aide to include the ability to read and write in English to the degree necessary to perform the tasks expected.

Language was also added that required the provider to comply with the *Code of Virginia* §32.1-162.9:1 regarding criminal record checks. (subsection C 1, c)

Language was added to the registered nurse section that requires the registered nurse to have two years of related clinical experience. The setting of the public health clinic and the home health agency has been added. Language was also added that states that the provider must comply with the *Code of Virginia* §32.1-162.9:1 regarding criminal record checks. (subsections C 2 b and c)

Language for the criminal records check was added to the requirements regarding the activities director section and the director's section. (subsections C 3, c and C 4)

Language regarding the transportation responsibilities was deleted from the regulations. (subsection D 4).

Language was added and deleted from the daily record section. The language deleted stated that the record must be signed weekly by the participant or representative. The language added includes the requirement that a copy of this record must be given to the participant or representative weekly. (subsection E 6)

12VAC30-120-50

Language was added to clarify that the recipient may continue to work or attend post-secondary school while they receive services under this waiver. Language was added that describes the requirements that must be met. (subsection A)

Language was added to the section on the registered nurse who must have two years of related clinical experience, which may include work in a rehabilitation hospital or as an LPN. Language was also added that states that the providers must comply with the *Code of Virginia §32.1-162.9:1* regarding criminal record checks. (subsections B 2, a and B 2, b)

Language was added (per the request of the workgroup) that states that the RN supervisor must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

The minimum frequency of these visits is every 30 days for recipients with a cognitive impairment and every 90 days for recipients who do not have a cognitive impairment. Language was added to include the definition of cognitive impairment, the requirements for the initial and follow-up visits and a statement that the recipient (if he does not have a cognitive impairment) has the choice of frequency of the supervisory visits (not to exceed 90 days). Language was also added to include a safeguard that if DMAS or the designated preauthorization contractor determines that the health, safety and/or welfare of a recipient is in jeopardy, DMAS, or the designated pre-authorization contractor, may require the provider's registered nurse to supervise the personal care aide every 30 days or more frequently. (subsection B 2, d)

Language was deleted that stated "Any change in the identity of the RN providing coverage shall be reported immediately to DMAS."

Language was added under the qualifications of the personal care aide to include the ability to read and write in English to the degree necessary to perform the tasks expected. Language was also added that states that providers must comply with the *Code of Virginia §32.1-162.9:1* regarding criminal record checks. (subsections B 3, a and B 3, d)

Language was added, also under the qualifications of the personal care aide, to include the requirement that the aide cannot be the parents of minor children, the recipients' spouses, or the legal guardian of the recipient. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members. (subsection B 3, e)

Language was deleted that described the procedure that the provider must follow when using substitute personal care aides. This information will now be located in the provider manual.

12VAC30-120-55. Personal Emergency Response System (PERS) services

This is a new section in the VAC created for the language for the PERS service. The language included in this section includes a description of the service, DMAS criteria for the service, service units and service limitations, provider requirements, and standards for the PERS equipment. Information regarding medication monitoring was added as a component of the PERS service.

12VAC30-120-60

Language was added about respite care and that it is distinguished from other services in the continuum of long-term care because it is specifically designed to focus on the need of the unpaid caregiver for temporary relief. Language was also added that the authorization of respite care is limited to 720 hours per calendar year. This was for clarification purposes since the old language limited respite to 30-24 hour days over a 12-month period. (subsection A)

Language was added to the section on the registered nurse. The registered nurse must have two years of related clinical experience, which may include work in a rehabilitation hospital or as an LPN.

Language was also added that states that the same providers must comply with the *Code of Virginia §32.1-162.9:1* regarding criminal record checks. (subsection B 2 a)

Language was added under the qualifications of the personal care aide to include the ability to read and write in English to the degree necessary to perform the tasks expected.

Language was also added that states that the providers must comply with the *Code of Virginia §32.1-162.9:1* regarding criminal record checks. (subsections B 3 a and B 3 e)

Language was added, also under the qualifications of the personal care aide, to include the requirement that the aide cannot be the parents of minor children receiving services paid for by Medicaid, the recipients' spouses, or legal guardian of the recipient. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members. (subsection B 3 f)

Language was added regarding the Licensed Practical Nurse. Language included that the LPN must be currently licensed to practice in the Commonwealth. Language was also clarified that states that the providers must comply with the *Code of Virginia §32.1-162.9:1* regarding criminal record checks. (subsection B 4, a)

Language was deleted that described the procedure that the respite care agency must follow when using substitute respite care aides. This information will now be located in the provider manual.

Language was added that states that respite care services cannot begin prior to preauthorization from the designated pre-authorization contractor. (subsection E)

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

DMAS anticipates that the proposed regulations will have a positive impact on the institution of the family and family stability. The proposed regulations may assist families and individuals with strong family ties to stay together instead of a family member being institutionalized.

These regulations will not increase nor decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.