Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-120
Regulation title	HIV/AIDS Waiver Program
Action title	HIV/AIDS Waiver Program
Document preparation date	December 30, 2003; NEED GOV APPROVAL BY 1/20/2004

This information is required for executive review (www.townhall.state.va.us/dpbpages/apaintro.htm#execreview) and the Virginia Registrar of Regulations (legis.state.va.us/codecomm/register/regindex.htm), pursuant to the Virginia Administrative Process Act (www.townhall.state.va.us/dpbpages/dpb_apa.htm), Executive Orders 21 (2002) and 58 (1999) (www.governor.state.va.us/Press_Policy/Executive_Orders/EOHome.html), and the *Virginia Register Form, Style, and Procedure Manual* (http://legis.state.va.us/codecomm/register/download/styl8_95.rtf).

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

This regulatory action adds coverage of consumer-directed personal assistance services and consumer-directed respite care services (12 VAC 30-120-165), to the HIV/AIDS waiver program (12 VAC 30-120-140 through 12 VAC 30-120-200). The two new consumer-directed services will be two of the seven services offered under the HIV/AIDS waiver. The other five previously existing services are: case management, agency-directed personal care, agency-directed respite care, private duty nursing, and nutritional supplements.

The other changes made to these proposed regulations include: (1) the addition of language regarding waiver eligibility desk reviews which the Centers for Medicare and Medicaid Services (CMS) mandated that DMAS perform; (2) the addition of language regarding criminal records checks for all compensated employees of personal care and respite care agencies; (3) the addition of language that states that personal care recipients may continue to work or attend post-secondary school, or both, while receiving services under this waiver; (4) the requirement of supervisory visits has been changed from every 30 days 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; (5) the addition of the requirement that the personal care aide be able to communicate effectively in English; (6) the addition of the definition of 'family members' for the purpose of defining who is qualified to perform personal care services; (7) the addition of the requirements of the qualifications for Licensed Practical Nurses (LPNs) providing respite care; and (8) editorial clarifications and corrections to the existing language.

There are no changes being made in this final regulation over those that were proposed for public comment period.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended sections of the Virginia Administrative Code (12 VAC 30-120-140 through 30-120-200) for the HIV/AIDS 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.

01/09/2003

Date

/s/ Patrick W. Finnerty, Director

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal source of legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly bill and chapter numbers, if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The Department of Medical Assistance Services (DMAS) derives its authority for this waiver program from the *Social Security Act* § 1915 (c) which permits the states to establish and pay for, with approval of the Centers for Medicare and Medicaid Services (the federal funding agency), community-based services that enable eligible individuals to avoid institutionalization.

The addition of consumer-directed services to the HIV/AIDS waiver was mandated by the General Assembly in the *2002 Acts of Assembly*, Chapter 899 Item 325 X. This provision

directed DMAS to add consumer-directed services to the HIV/AIDS waiver in an emergency regulation action.

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 March 17, 2003. 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 April 7, 2003.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.

The purpose of this action is to add the coverage of consumer-directed personal assistance services and consumer-directed respite care services (12 VAC 30-120-165), to the HIV/AIDS waiver program (12 VAC 30-120-140 through 12 VAC 30-120-200). The addition of consumer-directed personal assistance and consumer-directed respite care allows individuals to have more options regarding their care. The two new consumer-directed services will be two of the seven services offered under the HIV/AIDS waiver. The other five existing services include case management, agency-directed personal care, agency-directed respite care, private duty nursing, and nutritional supplements.

This proposal recommends changes to DMAS' permanent regulations, to supersede the existing emergency regulations. This regulatory action is expected to help protect the health, safety, and welfare of participants in this waiver. These regulations will provide services that 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. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The regulations affected by this action are: 12 VAC 30-120-140 through 12 VAC 30-120-200.

With the implementation of this regulatory change, two new services (consumer-directed personal assistance and consumer-directed respite care) will be added to the HIV/AIDS waiver. This new regulation outlines the requirements for consumer-directed services as well as the requirements that the personal/respite care assistant must follow in order to receive reimbursement from the Department of Medical Assistance Services (DMAS).

In the summer of 2002, DMAS convened a workgroup to assist with the development of the waiver renewal application to CMS, HIV/AIDS waiver manual and regulations. The workgroup is comprised DMAS staff, other state agencies, provider agencies, and two consumers. In order to make the changes to the waiver program that the workgroup and DMAS agreed upon and to permanently add the two new services to the waiver, new permanent regulations are required. Without these regulations, DMAS lacks the regulatory authority to require the provider to adhere to the agreed upon changes.

If consumers, who require personal care and respite care services utilize consumer-directed personal assistance and consumer-directed respite care instead of agency-directed personal care and respite care services, more aides employed by agencies will be available to provide direct services to consumers who require or prefer agency-directed personal care and respite care services. The effect of this will be to delay or prevent institutionalization of those consumers who require agency-directed personal care and/or respite care services.

For a variety of reasons, it has become difficult for personal/respite care agencies to provide these needed services to waiver recipients. As a result, many recipients who need personal and respite care services are not receiving them at all, putting their personal welfare at risk, and leaving such recipients at increased risk of institutionalization.

Consumer-directed services are services for which the recipient or family/caregiver agrees to be responsible for hiring, training, supervising, and firing of the personal assistant. These consumer-directed services are being added to this existing waiver program at the specific requests of recipients and family/caregivers. Recipients or family/caregivers who prefer to remain with the existing service model of agency-directed care will continue to have this as an available service option. No recipients or family/caregivers will be forced to use consumer-directed services.

A consumer-directed services facilitator is a DMAS-enrolled provider who is responsible for supporting the recipient and family/caregiver by ensuring the development and monitoring of the consumer-directed plan of care, providing employee management training, and completing

ongoing review activities as required by DMAS for consumer-directed personal assistance services and respite care services.

This regulatory change will also affect the agency-directed personal care services. It changes the requirement of supervisory visits from every 30 days in general to every 90 days for non-cognitively impaired recipients, which will allow recipients more freedom and privacy in their homes. 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, as indicated by the recipient's condition.

Adding facility-based respite care to this waiver, changing the definition of family members, and adding that recipients may work or attend post-secondary school while receiving services under this waiver are consistent with federal approval. Adding that DMAS must perform waiver desk reviews is also consistent with federal approval. The addition of information concerning criminal records checks is consistent with the *Code of Virginia*, § 32.1-162.9:1.

The changes proposed in these 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.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary 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 the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

The primary advantage for the Commonwealth's citizens regarding the addition of consumer-directed personal assistance and consumer-directed respite care is that it could greatly improve consumers' autonomy and ability to remain in the community without relying on a personal care agency to schedule aides' services. Also, most aides employed by personal care agencies, are employed during the day. Some consumers, who live on their own, require assistance at other times than just during the day. Some consumers will be able to remain with their families instead of being institutionalized. To the extent of their abilities, consumers will be able to function in their communities, attend school and continue employment. Another advantage is that since recipients who utilize agency-directed personal care services for their needs can utilize consumer-directed personal assistance or consumer-directed respite care, the agency-directed personal care aides would be more available to provide the direct personal care and respite care

services to recipients who prefer or require this mode of service delivery in order to avoid institutionalization.

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

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

There are no changes being made in this final regulation over those that were proposed for public comment period.

Public comment

Please summarize all comment received during the public comment period following the publication of the proposed stage, and provide the agency response. If no public comment was received, please so indicate.

DMAS' proposed regulations were published in the October 5, 2003, *Virginia Register* for their public comment period from October 5 through December 5, 2003. Comments were received from Medical College of Virginia/Infectious Disease Clinic and the Richmond City Health Department (both via electronic mail). A summary of the comments received and the agency's response follows.

Comment: The comments from the Medical College of Virginia/Infectious Disease Clinic concerned several subjects.

Recipients who have a medical need for nutritional supplements, but who are not ill enough to require personal care services.

A large part of the subcommittee's discussion was around the benefits of getting rid of the Karnofsky scale, 'since it no longer served as an appropriate or helpful tool, especially with nutritional supplement cases.' The discussion included the fact that many patients become nutritionally compromised either solely because of their HIV, or in combination with other co-morbid health conditions. 'However, these patients remain " functional" from a physical and cognitive/behavioral standpoint.' Such patients are ill enough to be on disability and Medicaid, and although physically independent, are now at a point where their nutritional status is compromised because of related or concurrent health conditions (muscle mass wasting, uncontrolled diabetes, renal or liver failure, etc.). The concern is that in order for a person to be eligible for this waiver's services, he or she has to be near, be at risk for, either nursing home admission or acute care hospitalization. For acute care hospitalization, the person has to have been hospitalized within three months of the screening, or is expected to

require hospitalization within one month (of the screening) if not provided with the waiver services. Who determines whether the patient is potentially going to be hospitalized within month? Does the pre-admission screener or the medical provider make this determination?

The concern is that most of the patients who have typically been screened for supplements and case management, up to this point, no longer appear to be eligible under the proposed criteria. Most patients remain functionally independent despite being nutritionally compromised. Are all patients now expected to meet not only a medical category/criteria and a functional/behavioral/cognitive category? If this is the case, it appears that few persons would meet criteria for this waiver until they are in need of personal care, and only then would their functional status be such that they might also meet criteria for nutritional supplements. This organization's position is that many patients can still qualify for supplements without necessarily needing personal care as well."

Agency Response: *The preadmission screener makes the determination. State law requires preadmission screeners be social workers, nurses or physicians, but a physician must sign the Uniform Assessment Instrument (UAI). The physician who signs the UAI is not the potential recipient's physician, but a physician who supervises the preadmission screeners. DMAS staff performs annual level of care reviews on AIDS Waiver recipients to determine whether they continue to meet level of care requirements. Staff who perform these reviews are Registered Nurses.*

All waiver recipients have in the past and will continue to be required to meet institutional eligibility requirements (medical and functional) in order to comply with federal regulatory requirements for home and community based services. This is not a change to this regulation.

Recipients requiring nutritional supplements without personal care no longer to receive case management

The other situation of concern is the recommendation that all cases requiring nutritional supplements without personal care will no longer be given case management. Historically, there has been little to no case management in the rural parts of the Commonwealth and that case management provider shortages have been experienced in urban areas as well. Currently, case management services are still being authorized when patients are approved for supplements, provided that such service providers are available in the person's geographic area. There are some cases where persons may not need a case manager to make home visits regularly because such individuals are fully capable of evaluating or obtaining their own needs as required. However, many patients may require added emotional supports and communication with medical providers and clinic-based social workers to ensure that their needs are consistently addressed and that services are revised, when necessary. It would therefore be very important to at least allow for the option of enrolling patients in case management in situations where it is medically and/or psychosocially indicated.

The MCV medical providers were asked by DMAS to review the nutritional status evaluation form, weight status form, as well as medical criteria suggested for nutritional supplement

approval. A copy of the suggested changes and recommendations made by these medical providers was included. These patients have the potential of becoming very nutritionally compromised without necessarily being functionally or physically debilitated (although many of course can). In many cases, it may be very difficult to determine when a patient may be within one month of hospitalization. In these cases, providers are simply making a judgment call. MCV continues to be a strong supporter of the services offered under the Medicaid HIV waiver program. This organization's concern is, however, that the MCV patients may now have difficulty in accessing some of the waiver services or else may have to wait until their conditions worsen considerably before meeting criteria as now being interpreted.

Recommended Changes for Nutritional Supplement Program (evaluation form): The following changes to this form are being recommended:

Change title of form to: Initial Evaluation Form for Nutritional Supplements

Patient Information: No changes

Data Elements: Include height, current weight, ideal weight and previous weight only. Exclude sections on Formula tolerance, and tube or stoma sight assessment.

Keep C. as is.

Progress Statement: Take this out completely (since this will serve only as initial prescription and subsequent orders will be generated on an actual prescription pad).

Add section: Justification for Nutritional Supplements: Check all that apply-

-Weight loss as defined on Weight Status Worksheet.

-Malnutrition as evidenced by changes in muscle mass (wasting) or lab values.

-Medication side effects (such as nausea, vomiting, decrease in appetite) that make it difficult to tolerate prescribed medication regimen.

Physician's Order for Nutritional Supplements: Change "Physician" to "Medical Provider" in event that you get authorization to let a midlevel practitioner sign this form as well as a physician. Take "category" out. Recommend that there be enough space to order up to three supplemental products with use of only one form. Maintain "Total caloric order per day", but add "calories per can/package for each of three potential products.

Exclude G.

Assessor Information: Keep as is, but with hope that a nurse practitioner and physician assistant can sign as well as a physician (since they have prescription privileges in Va.)

Agency Response: The agency does not intend to make any changes to the Nutritional Supplement Program Evaluation Form at this time.

Medical Criteria for Nutritional Supplements:

Adults: Patient must meet one or more of the following indicators:

Weight loss per current guidelines. The use of CD 4 count or viral load is not recommended in determining need for nutritional supplements because other factors play a bigger role in understanding nutritional risk or status. Also, the use of BIA is not recommended because equipment is very costly and it's doubtful that other providers have this equipment.

Medically-related malnutrition, or risk for malnutrition, as evidenced by any one or combination of the following:

Abnormal albumin functioning (below 3.5)

Liver or renal failure

Poorly controlled diabetes as evidenced by unstable blood sugars

Wasting as evidenced by loss of muscle mass and/or subcutaneous fat in face or extremities

Medication side effects, such as nausea, vomiting, or decreases in appetite, making it difficult to tolerate prescribed medication regimen.

Children:

Diagnosis of Failure to Thrive, based on inadequate growth (height/weight) in relation to child's age. HIV-infected children, based on the nature of their illness, often cannot consume the number of calories needed for age-appropriate growth. This organization is seeking its pediatrician's recommendations about desirable percentage goals for children's growth charts and will advise of the medical recommendation.

Criteria for Disenrollment:

Patient will demonstrate evidence of medical stability (in terms of weight range, laboratory values, opportunistic infections, co-morbid health conditions) for 6-12 months. Once stability has been demonstrated, nutritional supplement or supplements will be stopped for a three months test period, while other waiver services continue, to determine if the patient can maintain he nutritional status. If patient's nutritional status deteriorates, as evidenced by wasting, weight loss, children failing to thrive, during this time, then nutritional supplements would be reinstated. If condition remains stable, patient will then be disenrolled from this service.

Agency Response: Disenrollment from waivers, by federal law, must occur when the individual no longer meets the admission criteria for the alternate institution, which is a hospital or a nursing facility for the AIDS Waiver. This requirement is mandated for all waivers and cannot be changed (42 CFR § 302(c)(2)). The Governor's 2004-2006

introduced budget mandates combining the AIDS Waiver with the Elderly and Disabled Waiver. In light of changes to the AIDS Waiver population, and the possible combination of the waivers, all AIDS Waiver services will be reevaluated. The Governor's 2004 Budget (Item 326 UU) provides DMAS with the authority to combine the AIDS Waiver with the Elderly and Disabled Waiver. If this budget item is passed by the General Assembly, DMAS will seek approval from CMS to combine these waivers and will promulgate emergency regulations within 280 days of the enactment of the Appropriations Act.

According to federal regulations, all waiver recipients must have an evaluation for the level of care for the alternate institution, in this case a hospital or nursing facility, and in order to be eligible, there must be a reasonable indication that the recipient might need waiver services in the near future (that is, a month or less) unless he or she receives home or community based services. (42 C.F.R. 441.302 (c)(1)). Waivers are an alternative to institutional placement and the admission criteria for the waiver the alternate institution must, by federal law, be the same. (42 C.F.R. 441.303 (b) (2)) If people do not meet the admission criteria for the institution, they are not eligible for the waiver. This is not a change in these regulations and no clarifications can be made to change this standard.

Comment: The comments from the Richmond City Health Department concerned several subjects.

It appears that, NO ONE may be approved for the HIV waiver unless: (a) he meets full nursing facility criteria, which means functional dependency in ADLs, medical/nursing needs and/or behavior and orientation impairment, plus a nursing facility placement risk; Or, (b) he has been in the hospital within the last three months and therefore meets hospitalization risk criteria.

The issue with this part of the proposed regs is that it eliminates those clients whose only need is for nutritional supplements, while they are still functionally able to manage their own ADLs and have, perhaps, only minimal cognitive impairment. Without the nutritional supplements, these clients would progress to the point of hospitalization and/or death. But it seems they cannot be approved for this waiver service unless they have deteriorated to the point of needing the institutional level of care or have been recently hospitalized. This seems to be a real Catch 22. Either the regs need to be clarified or expanded in wording or the issue of nutritional supplements needs to be separately addressed.

This organization agrees with MCV that many of the clients who only need nutritional supplements will fall through the cracks and receive nothing because they do not meet the (proposed regs') criteria. Many of these patients do not meet the nursing facility criteria or the hospitalization-risk criteria but are severely nutritionally compromised. Without the supplements, these patients rapidly deteriorate to needing institutionalization of some kind. We do not feel that this type of situation is addressed in the currently proposed regs.

Agency Response: Disenrollment from waivers, by federal law, must occur when the individual no longer meets the admission criteria for the alternate institution, which is a hospital or a nursing facility for the AIDS Waiver. This requirement is mandated for all

waivers and cannot be changed (42 CFR § 302(c)(2)). According to federal regulations, all waiver recipients must have an evaluation for the level of care for the alternate institution, in this case a hospital or nursing facility, and in order to be eligible, there must be a reasonable indication that the recipient might need waiver services in the near future (that is, a month or less) unless he or she receives home or community based services. (42 C.F.R. 441.302 (c)(1)). Waivers are an alternative to institutional placement and the admission criteria for the waiver the alternate institution must, by federal law, be the same. (42 C.F.R. 441.303 (b) (2)) If people do not meet the admission criteria for the institution, they are not eligible for the waiver. This is not a change in these regulations and no clarifications can be made to change this standard.

The Governor's 2004-2006 introduced budget mandates combining the AIDS Waiver with the Elderly and Disabled Waiver. In light of changes to the AIDS Waiver population, and the possible combination of the waivers, all AIDS Waiver services will be reevaluated. The Governor's 2004 Budget (Item 326 UU) provides DMAS with the authority to combine the AIDS Waiver with the Elderly and Disabled Waiver. If this budget item is passed by the General Assembly, DMAS will seek approval from CMS to combine these waivers and will promulgate emergency regulations within 280 days of the enactment of the Appropriations Act. DMAS will seek to combine the waivers with an effective date of no later than September 1, 2004. At that time, all waiver services will be evaluated for inclusion in the combined waiver.

All changes made in this regulatory action

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail new provisions and/or all changes to existing sections.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
140		Definitions.	Modified/added/deleted numerous definitions as appropriate to conform to waiver changes.
150		General coverage conditions.	Language was modified to clarify that waivers serve only individuals who would otherwise be placed in an inpatient hospital or nursing facility and the responsibilities of the Preadmission Screening Team. (C, 1 and 2)
150		General coverage conditions.	New language regarding preauthorization of waiver services. (C, 3)
150		General coverage conditions.	New language clarifies the Preadmission Screening Team's responsibilities and the criteria for admission to the waiver. (C, 4-

			6)
150		General coverage conditions.	New language clarifies that Medicaid will not pay for any services delivered prior to the authorization date approved by the screening team and the date of the physician signature on the Medicaid Funded Long-Term Care Service Authorization form.
150		General coverage conditions.	New language clarifies the requirements for Preadmission Screening. (C, 8)
150		General coverage conditions.	Information regarding recipient and provider appeals was added. (D)
160		General conditions and requirements.	Information was modified to refer to the correct citations. (A)
160		General conditions and requirements.	Information was modified to add information regarding the provider's requirements. (B, 1-15)
160		General conditions and requirements.	Information was modified regarding provider participation requirements. (C, D, E)
160		General conditions and requirements.	Information was added regarding DMAS responsibilities. (F)
160		General conditions and requirements.	New language clarifies that the recipient has the choice of provider agencies if there is more than one provider agency in the community and that the recipients will have the option of selecting the provider agency of his choice from among those agencies which can appropriately meet the recipient's needs. (G)
160		General conditions and requirements.	New language regarding provider's ability to terminate participation in Medicaid. (H)
160		General conditions and requirements.	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. These proposed regulations change it t0 30 days to be consistent with other waiver programs. (I)
160		General conditions and requirements.	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 Medicaid provider appeals regulations. (J)

160		General conditions and requirements.	New language regarding felony convictions of providers. (K)
160		General conditions and requirements.	Language modified to include information about the designated preauthorization contractor and the DMAS-122 form. (L, M)
160		General conditions and requirements.	New language clarifies decreases in amount of authorized care by the provider agency. The new language specifies that the provider agency 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 individual. Language is also included that specifies what the recipient may do if he disagrees with this decrease. (N, 1)
160		General conditions and requirements.	New language clarifies increases in amount of authorized care by the provider agency. (N, 2)
160		General conditions and requirements.	New language regarding non-emergency termination of services by the participating provider. (N, 3)
160		General conditions and requirements.	New language regarding emergency termination of services by the participating provider. (N, 4)
160		General conditions and requirements.	New language regarding termination of services by DMAS or the designated preauthorization contractor. (N, 5)
160		General conditions and requirements.	New language regarding what the recipient can do if he disagrees with the service termination decision. (N, 6)
160		General conditions and requirements.	Language was modified regarding suspected abuse or neglect. Language was added to require the abuse or neglect be reported immediately and that it must be reported to Adult/Child Protective Services. (O)
160		General conditions and requirements.	Language was modified regarding DMAS' responsibility for monitoring compliance with participation standards. (P)
160		General conditions and requirements.	New language regarding waiver eligibility desk reviews. DMAS added this language per CMS' request that DMAS perform this function. (O)
165		Consumer-directed services.	New language added to include information regarding consumer-directed personal assistance and consumer-directed respite care. The information includes the service definition, criteria, service units and service limitations, provider qualifications, service facilitation provider responsibilities, recipient responsibilities, and fiscal agent

			responsibilities. (A-G)
170		Case management services.	New language regarding general case management information. (A)
170		Case management services.	Language was modified regarding case management provider participation requirements and responsibilities. (B)
180		Agency-directed personal care services.	New language that provides that the recipient may continue to work or attend post-secondary school, or both, while they receive services under this waiver. Language was added that describes the requirements that must be met. (A)
180		Agency-directed personal care services.	New language regarding the Americans with Disabilities Act and the Rehabilitation Act of 1973. (B)
180		Agency-directed personal care services.	Deleted the requirement that the provider must demonstrate a prior successful delivery of health care services. (D)
180		Agency-directed personal care services.	New language 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 requirements for criminal record checks apply to registered nurses. (D, 2, a-b)
180		Agency-directed personal care services.	New language regarding when the registered nurse must make home assessment visit. (D, 2, c)
180		Agency-directed personal care services.	New language 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 determines that the health, safety and/or welfare of a recipient 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 often as required by the plan of care. (D, 2, d)
180		Agency-directed personal care services.	New language regarding contents of the registered nurses' summary notes. (D, 2, e)
180		Agency-directed personal care services.	New language states that if there is a delay in the registered nurses' supervisory visits, because the recipient was unavailable, the reason for the delay must be documented in the recipient's record. (D, 2, h)
180		Agency-directed personal care services.	New language was added under the qualifications of the personal care aide to include the ability to communicate effectively in English. This includes the ability to read, write and speak in English. (D, 3, a)
180		Agency-directed personal care services.	New language added that states that the same requirements for criminal record checks apply to personal care aides. (D, 3, d)
180		Agency-directed personal care services.	New language added, also under the qualifications of the personal care aide, to include the requirement that the aide cannot be the parents of minor children, or the individuals' spouses. 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. (D, 3, e-f)
180		Agency-directed personal care services.	Language was clarified regarding the required documentation for recipients' records. (C, 1-8)
190		Agency-directed respite care services.	New language 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. (A)
190		Agency-directed respite care services.	Deleted the requirement that the provider must demonstrate a prior successful delivery of health care services. (B)

190		Agency-directed respite care services.	New language 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. (B, 2, a)
190		Agency-directed respite care services.	New language added that states that the same requirements for criminal record checks apply to registered nurses. (B, 2, b)
190		Agency-directed respite care services.	New language added that the registered nurse shall be available to the respite care aide for conference pertaining to recipients being served by the aide and shall be available to the aides by telephone at all times that aides are providing services to respite care recipients. (B, 2,g)
190		Agency-directed respite care services.	New language added to state that if there is a delay in the registered nurses' supervisory visits, because the recipient was unavailable, the reason for the delay must be documented in the recipient's record. (B, 2, h)
190		Agency-directed respite care services.	New language added under the qualifications of the personal care aide to include the ability to communicate effectively in English. This includes the ability to read, write and speak in English. (B, 3, b)
190		Agency-directed respite care services.	Language was also added that states that the same requirements for criminal record checks apply to personal care aides. (B, 3, e)
190		Agency-directed respite care services.	New language added, also under the qualifications of the personal care aide, to include the requirement that the aide cannot be the parents of minor children, or the individuals' spouses. 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. (B, 3, f-g)
190		Agency-directed respite care services.	New language added regarding the Licensed Practical Nurse. Language included that the LPN must be currently licensed to practice in the Commonwealth. Language was also added that states that the same requirements for criminal record checks apply to licensed

			practical nurses. (B, 4, a)
190		Agency-directed respite care services.	New language added regarding skilled respite care and supervision of LPNs. (B, 4, f-g)
190		Agency-directed respite care services.	New language added regarding required documentation for recipients' records. (C, 1-9)
195		Enteral nutrition products	This section was added for enteral nutrition products. This section includes information regarding general requirements and conditions, service units and limitations, and provider responsibilities. (A-C)
200		Private duty nursing services.	New language added regarding the purpose of private duty nursing. (A)
200		Private duty nursing services.	Language was modified regarding the provider participation conditions. (B)
200		Private duty nursing services.	New language 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. (B, 4, a)
200		Private duty nursing services.	New language added that states that the LPN shall be currently licensed to practice in the Commonwealth. (B, 4, b)
200		Private duty nursing services.	New language added regarding the limits to the private duty nursing service. (C, 1-3)
200		Private duty nursing services.	New language added regarding provider reimbursement for the private duty nursing service. (D, 1-4)
200		Private duty nursing services.	New language added regarding the assessment and plan of care requirements for the private duty nursing service. (E, 1-2)
200		Private duty nursing services.	New language added regarding patient selection of waiver services for the private duty nursing service. (F, 1-3)
200		Private duty nursing services.	New language added regarding reevaluation requirements and utilization review. (G)
200		Private duty nursing services.	New language added regarding registered nurse supervisory duties. (H, 1-3)
200		Private duty nursing services.	New language added regarding required documentation for recipients' records. (I, 1-9)

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability.

Consumer-directed services will strengthen the authority and rights of recipients and their caregivers to direct the care needed. Consumer-directed services will encourage self-sufficiency, self-pride, and the assumption of responsibility to the greatest levels possible. It has been DMAS' experience that recipients who use consumer-directed services require no more services than if they were offered by an agency and sometimes use fewer hours because they can tailor the services to their individual needs.