Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code	12 VAC 30-120
Regulation title	HIV/AIDS Waiver Program
Action title	HIV/AIDS Waiver Program
Document preparation date	; GOV APPROVAL NEEDED BY SEPT 11TH

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

Please provide a brief summary of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation. Do ***not*** *state each provision or amendment or restate the purpose and intent of the regulation.*

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.

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 1, 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.

The Office of the Attorney General has certified that the agency has the statutory authority to promulgate these proposed regulations and also that they conform with applicable state and federal laws.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss 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 briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (Provide more detail about these changes in the "Detail of changes" 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.

All of 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.

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

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 there are no disadvantages to the public or the Commonwealth, please 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.

Financial impact

Please identify the anticipated financial impact of the proposed regulation and at a minimum provide the following information:

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	There is no increase in the cost to the Commonwealth to add these services.
Projected cost of the regulation on localities	There is no projected cost of the regulation on localities.
Description of the individuals, businesses or other entities likely to be affected by the regulation	Businesses likely to be affected by the proposed regulations include personal care agencies since the agencies will provide fewer

	personal care aides to provide personal care services. It is anticipated that the shortage of personal care aides will lessen since some consumers who currently receive agency-directed personal care and respite care can now receive consumer-directed personal assistance and consumer-directed respite care services instead.
Agency's best estimate of the number of such entities that will be affected	The Preadmission Screening (PAS) Teams will continue to screen consumers to determine if they are eligible to receive services under the HIV/AIDS waiver. The existing PAS Teams, who already screen recipients for HIV/AIDS waiver services, will screen recipients who wish to receive consumer-directed personal assistance and consumer-directed respite care services if they are being screened for admission to the waiver. WVMI, the DMAS preauthorization contractor, will perform preauthorization for the two new services. WVMI already has staff who perform preauthorization for the HIV/AIDS waiver. DMAS staff will perform utilization review on the new service. DMAS also already has staff who perform utilization review.
Projected cost of the regulation for affected individuals, businesses, or other entities	None

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action.

There are no other alternatives that DMAS has considered, in response to the request for consumer-directed services, as this addition of consumer-directed services enable consumers to remain in their homes and communities instead of being institutionalized.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

The HIV/AIDS waiver workgroup has been reviewing and advising DMAS in informal workgroup meetings as well as individually by telephone and e-mail.

Additional recommendations may be incorporated into the proposed regulations during the final comment period.

DMAS' emergency regulations were published in the April 7, 2003, *Virginia Register*. The Notice of Intended Regulatory Action was also published in the April 7, 2003, in the *Virginia Register*. No comments were received.

Impact on family

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.

Detail of changes

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

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

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)