Choices for Care

7.102.1 Choices for Care Purpose and Scope (04/15/2020, GCR 19-059)

(a) The "Choices for Care" program operates within the State's Global Commitment to Health 1115 Waiver providing long-term services and supports to aging or physically disabled Vermont adults.

(b) The Choices for Care program is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and is managed in compliance with CMS terms and conditions of participation.

(c) The primary goal of the Choices for Care waiver is to provide Vermonters with equal access to licensed nursing facility, licensed residential care/assisted living, or home and community-based services, consistent with their choice.

7.102.2 Definitions

For the purposes of this rule, the term:

(a) **"Activities of Daily Living"** (ADLs) means dressing and undressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility in and around the home, and eating.

(b) **"Adult Day Services"** means a range of health and social services provided at a location that has been certified by DAIL.

(c) **"Adult Family Care" (AFC)**, also known as "shared living" means 24-hour care and supervision provided by an approved unlicensed home provider, limited to a maximum of two individuals in each setting, and managed by an agency authorized by DAIL.

(d) **"Applicant"** means an individual who has submitted a Choices for Care application and whose eligibility status is pending.

(e) **"Assistive Devices" means** devices used to increase, maintain, or improve the individual's functional capabilities.

(f) **"Authorized Agency"** means an agency authorized by DAIL to provide and arrange for Adult Family Care to eligible participants.

(g) **"Behavioral Symptoms"** means behavior that is severe, frequent and requires a controlled environment to provide continuous monitoring or supervision.

(h) **"Case Management"** is a home-based service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes. Case Management Services assist DAIL in monitoring the quality, effectiveness and efficiency of CFC services.

(i) **“Commissioner”** means the Commissioner of the Department of Disabilities, Aging and Independent Living.

(j) **“Companion/Respite”** means a home-based service that provides non-medical supervision and socialization for participants as determined by the needs of the individual, and which is limited in combination with Respite care.

(k) **“Controlled Environment”** means an environment that provides continuous care and supervision.

(l) **“DAIL”** means the Department of Disabilities, Aging and Independent Living.

(m) **“Date of Application”** means the date that an application is received by the Department of Vermont Health Access (DVHA).

(n) **“DVHA”** means the Department of Vermont Health Access.

(o) **“Eligibility Groups”** means the groups of people who are found to meet the eligibility criteria for the Highest, High, or Moderate Needs groups.

(p) **“Enhanced Residential Care”** means a 24-hour package of services provided to individuals residing in a licensed Residential Care Home, Assisted Living Residence or Home for the Terminally Ill.

(q) **“Enrolled”** means that an applicant has been found eligible, has been assigned to an eligibility group, and is authorized to receive services.

(r) **“Extensive Assistance”** means one of five levels of assistance used when assessing an applicant or participant’s self-performance of Activities of Daily Living. Levels range from “Independent” to “Total” assistance. An applicant or participant is assessed as needing “Extensive Assistance” when hands on assistance or standby assistance is needed to complete the task safely within a reasonable period of time and when the assistance has been provided three or more times in the last seven days.

(s) **“Fiscal/Employer Agent (F/EA)”** means an organization that contracts with the State to provide assistance to eligible participants with payroll, taxes, and other financial management tasks for consumer or surrogate-directed self-managed home-based services.

(t) **“Flexible Choices”** means a home-based High and Highest Needs Group service option that allows an eligible consumer or surrogate employer to manage a flexible budget.

(u) **“Flexible Funds”** means a home-based Moderate Needs Group service option that provides access to a limited amount of funds that may be used to purchase needed goods or services.

(v) **“High Needs Group”** means participants who have been found to meet the High Needs Group clinical eligibility criteria and have been authorized to receive services.

(w) **“Highest Needs Group”** means participants who have been found to meet the Highest Needs Group clinical eligibility criteria and have been authorized to receive services.

(x) **“Home-Based”** means the setting in which Choices for Care services are provided to a participant who resides in their own home. This does not include a licensed facility or a formal Adult Family Care home provider. Home-based services do not cover 24-hours per day of services.

(y) **“Home and Community-Based Services”** means all long-term services and supports provided under these regulations, with the exception of those provided at licensed facilities.

(z) **“Homemaker Services”** means a home-based service that assists a participant with Instrumental Activities of Daily Living such as shopping, cleaning, and laundry provided to help people live at home in a healthy and safe environment.

(aa) **“Home Modifications”** means physical adaptations to the individual’s home that help to ensure the health and welfare of the individual or that improve the individual’s ability to perform ADLs, IADLs, or both.

(bb) **“Imminent Risk”** means there is a current threat or an event that will threaten an individual’s personal health and/or safety within 45 days.

(cc) **“Individualized Budget”** means a dollar amount that has been authorized by DAIL for long-term services and supports to a participant who self-directs their Choices for Care services in the home-based setting.

(dd) **“Informed Consent”** means a process by which an individual or an individual's authorized representative (as defined in HCAR 8.100.2) makes choices or decisions based on an understanding of the potential consequences of the decision, free from any coercion, and fully informed about all feasible options and their potential consequences.

(ee) **“Instrumental Activities of Daily Living”** (IADLs) means meal preparation, medication management, telephone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment.

(ff) **“Long-Term Services and Supports”** is a general term referring to services covered by the Choices for Care 1115 Medicaid Waiver as described in these regulations.

(gg) **“Moderate Needs Group”** means participants who have been found to meet the Moderate Needs Group eligibility criteria and who have been authorized to receive services.

(hh) **“Participant"** means an individual for whom services have been authorized in accordance with these regulations.

(ii) **“PASRR”** means Pre-Admission Screening and Resident Review (PASRR) that is a federally required

process (Omnibus Budget Reconciliation Act of 1987) to determine whether placement or continued stay in a nursing facility is appropriate, and to identify the specialized services an individual with mental health or intellectual disability needs, including services the nursing facility can provide and services that must be arranged separately.

(jj) **“Person-Centered Planning”** means a process supporting the participant in accordance with 42 CFR § 441.301(c)(1) that builds upon the person’s capacity to engage in activities that promote community life and that honor the person’s preferences, choices, and abilities and which involves families, friends, and professionals as the individual desires or requires.

(kk) **“Personal Care”** means assistance to participants with ADLs and IADLs that is essential to the individual’s health and welfare.

(ll) **“Personal Emergency Response Systems (PERS)**” means electronic devices that enable participants to secure help in an emergency and provided by a vendor that has been authorized by DAIL.

(mm) **“Physically Aggressive Behavior”** means hitting, shoving, scratching, or sexual assault of other persons. The behavior must be severe and frequent, requiring a controlled environment to provide continuous monitoring or supervision.

(nn) **“Provider”** means any individual, organization, or agency that has been authorized by DAIL to provide Long-Term Services and Supports and has enrolled as a Vermont Medicaid provider.

(oo) **“Provider Qualifications”** means the requirements established by DAIL for providers of specific services, including any regulations pertaining to each provider.

(pp) **“Quality Management”** means a set of integrated tools and practices used to maximize its effectiveness, efficiency and performance, with a primary focus on participant outcomes.

(qq) **“Reimbursement”** means payment made by Vermont Medicaid to a provider for the provisions of services.

(rr) **“Resists Care”** means unwillingness or reluctance to take medications, injections or accept ADL assistance. Resisting care does not include instances where the individual has made an informed choice not to follow a course of care (e. g., individual has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment). Resistance may be verbal or physical (e. g., verbally refusing care, pushing caregiver away, scratching caregiver).

(ss) **“Respite Care”** means relief from caregiving and supervision for primary caregivers.

(tt) **“Service Authorization”** means a communication through which services are authorized by DAIL, which guides the delivery of services and Medicaid payment.

(uu) **“Service Standards”** means the requirements established by DAIL for the delivery of specific services.

(vv) **“Significant Change”** means a change in condition or circumstances that substantially affects an individual’s need for assistance including increases in functional independence, decreases in functional independence, and a change in other services or support provided by family and friends.

(ww) **“Total Assistance”** means one of five levels of assistance used when assessing an applicant or participant’s self-performance of Activities of Daily Living (ADL). Levels range from “Independent” to “Total” assistance. An applicant or participant is assessed as needing “Total Assistance” when totally dependent on others to complete the task safely within a reasonable period of time.

(xx) **“Variance”** means an exception to or exemption from these regulations granted by DAIL as allowed under applicable statute and regulation.

(yy) **“Verbally Aggressive Behavior”** means threatening, screaming at, or cursing people. The behavior must be severe and frequent, and because of its hostile nature, requires consistent planned behavioral interventions and approaches requiring a controlled environment to provide continuous monitoring or supervision.

(zz) **“Wandering”** means locomotion with no discernible, rational purpose by an individual who behaves as one who is oblivious to his or her physical or safety needs, and which locomotion presents a clear risk to the individual. Wandering may be manifested by walking or wheelchair. Pacing back and forth is not considered wandering.

7.102.3 General Policies

(a) Services shall be based on person-centered planning and shall be designed to ensure quality and protect the health and welfare of the individuals receiving services.

(b) Services shall be provided in a cost-effective and efficient manner, preventing duplication, unnecessary costs, and unnecessary administrative tasks.

(c) DAIL shall manage services so as to use resources efficiently and to maximize the benefits and services available to the greatest number of eligible individuals.

(d) DAIL shall administer the Choices for Care (CFC) program in accordance with these regulations, the CMS terms and conditions, and applicable state and federal law.

(e) Eligible individuals shall be informed of feasible service alternatives.

(f) DAIL encourages any applicant or participant who disagrees with a decision made by the State to contact State program staff person who made the decision to try to resolve the disagreement informally.

7.102.4 Covered Services

Choices for Care services approved for eligible participants include:

Setting	Service	Eligibility Group	Maximum
Home-Based	Adult Day	High/Highest Needs	Up to 12 hours per day
		Moderate Needs	Up to 50 hours per week
	Assistive Devices & Home Modifications	High/Highest Needs	Up to the current rate on file per calendar year
	Case Management	High/Highest Needs	Up to 48 hours per calendar year.
		Moderate Needs	Up to 24 hours per calendar year.
	Companion/Respite (agency directed)	High/Highest Needs	Up to 720 hours per calendar year
	Flexible Funds	Moderate Needs	Up to the amount of the individualized budget
	Homemaker	Moderate Needs	Up to 6 hours per week
	Personal Care (agency directed)	High/Highest Needs	Up to the amount of the participant's authorized service plan or individualized budget. IADLs shall not exceed 4.5 hours/week.
	Personal Emergency Response	High/Highest Needs	Up to the current monthly rate on file plus a one-time set-up fee
	Fiscal Employer Agent (F/EA) Services	High/Highest/Moderate Needs	Up to the rate on file as negotiated by State contract.
	Self-Directed Services: Flexible Choices, Consumer and Surrogate Directed Personal Care, Respite, Companion	High/Highest Needs	Up to the amount of the individualized budget
Adult Family Care	Case management, personal care, respite, assistive devices/home	High/Highest Needs	Up to the bundled daily tier rate on file based on

	modifications, community participation in a shared living setting.		the participant's authorized service plan
	Adult Day	High/Highest Needs	Up to 12 hours per day
Enhanced Residential Care	Bundled daily rate to cover 24-hour services in an approved Vermont licensed care home	High/Highest Needs	Up to the authorized tier rate on file
Nursing Facility	Bundled daily rate to cover 24-hour services in a facility licensed according to the 42 CFR § 483, Subpart B and Vermont regulations	High/Highest Needs	Current rate on file

Individual service standards are managed by DAIL and can be found in the Choices for Care Program Manuals and align with the 1115 Global Commitment to Health waiver Special Terms and Conditions.

Choices for Care service rates and codes may be found on the Adult Services Division website or by contacting the Vermont Medicaid fiscal agent.

7.102.5 Eligibility

(a) High/Highest Needs Group:

(1) Individuals who wish to enroll in the Choices for Care Highest or High Needs Groups shall complete an application and file it with the Vermont Medicaid.

(2) Applicants must meet clinical, financial, categorical, and non-financial (e.g. residence, citizen/immigration status, etc.) eligibility requirements based on criteria set for each eligible group.

(3) DAIL shall verify that applicants applying for Choices for Care in a nursing facility have had a PASRR completed prior to granting clinical eligibility.

(4) DAIL shall make a decision regarding clinical eligibility for Choices for Care within 30 days of receiving the application.

(5) DAIL shall review clinical eligibility once per year, at minimum, for all active participants.

(6) Clinical Eligibility:

(A) Highest Need clinical eligibility requires at least one of the following:

(i.) Extensive or total assistance with at least one of the following Activities of Daily Living (ADLs): toilet use; eating; bed mobility; or transfer and require *at least* limited assistance with any other ADL.

(ii.) Severe impairment with decision-making skills or a moderate impairment with decision-making skills and one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered:

Wandering	Verbally Aggressive Behavior
Resists Care	Physically Aggressive Behavior Behavioral
Symptom	

(iii.) At least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis:

Stage 3 or 4 Skin Ulcers	Ventilator/ Respirator
IV Medications	Naso-gastric Tube Feeding
End Stage Disease	Parenteral Feedings
2nd or 3rd Degree Burns	Suctioning

(iv.) An unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to, at least one of the following:

Dehydration	Internal Bleeding
Aphasia	Transfusions
Vomiting	Wound Care
Quadriplegia	Aspirations
Chemotherapy	Oxygen
Septicemia	Pneumonia
Cerebral Palsy	Dialysis
Respiratory Therapy	Multiple Sclerosis
Open Lesions	Tracheotomy
Radiation Therapy	Gastric Tube Feeding

(v.) DAIL shall enroll an individual in the Highest Needs Group when it determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. DAIL may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

1. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse),

2. Loss of living situation (e.g. fire, flood),

3. The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.), or

4. The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.).

(B) High Need clinical eligibility requires at least one of the following:

(i.) Individuals who require extensive-to-total assistance on a daily basis with at least one of the following ADLs:

Bathing	Dressing
Eating	Toilet Use
Physical Assistance to Walk	

(ii.) Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of, the following:

Gait Training	Speech
Range of Motion	Bowel or Bladder Training

(iii.) Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following:

Bathing	Dressing
Eating	Toilet Use
Transferring	Personal Hygiene

(iv.) Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self:

Constant or Frequent Wandering Behavioral
Symptoms
Physically Aggressive Behavior Verbally
Aggressive Behavior

(v.) Individuals who require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a daily basis and have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including, but not limited to, the following:

Wound Care	Suctioning
Medication Injections	End Stage Disease
Parenteral Feedings	Severe Pain Management
Tube Feedings	

(vi.) Individuals whose health condition shall worsen if services are not provided or if services are

discontinued upon reassessment due to clinical ineligibility.

(vii.) Individuals whose health and welfare shall be at imminent risk if services are not provided or if services are discontinued upon reassessment due to clinical ineligibility.

(C) Moderate Needs Group clinical eligibility requires at least one of the following:

(i.) Individuals who require supervision or any physical assistance three or more times in seven days with any single ADL or IADL, or any combination of ADLs and IADLs.

(ii.) Individuals who have impaired judgment or decision-making skills that require general supervision on a daily basis.

(iii.) Individuals who require at least monthly monitoring for a chronic health condition.

(iv.) Participants whose health condition shall worsen if services are not provided or if services are discontinued upon reassessment due to clinical ineligibility.

(7) <u>Financial, Non-Financial, and Categorical Eligibility</u>

(A) High/Highest Need Group financial, non-financial, and categorical eligibility follows the Medicaid rules for Long-Term Care eligibility found in the Health Benefits, Eligibility and Enrollment (HBEE) rules on the Agency of Human Services website.

(B) Moderate Needs financial eligibility is based on self-reported income and resources.

(i.) Countable Income is all sources of income, including Social Security, SSI, retirement, pension, interest, VA benefits, wages, salaries, earnings and rental income, whether earned or unearned. The income standard for the Moderate Needs Group is met if the adjusted monthly income of the individual (and spouse, if any) is less than 300% of the Vermont supplemental security income (SSI) payment standard for one person (or couple) in the community after deducting recurring monthly medical expenses (including but not limited to prescriptions, medications, physician bills, hospital bills, health insurance premiums, health insurance co-pays, and medical equipment and supplies). Adjusted monthly income is calculated by dividing the countable resources above $10,000 by 12 months then adding that amount to the countable income.

(ii.) Countable resources above $10,000 are used when calculating an individual’s adjusted income. Countable resources include cash, savings, checking, certificates of deposit, money markets, stocks, bonds, trusts that an individual (or couple) owns and could easily convert to cash to be used for his or her support and maintenance, even if the conversion results in the resource having a discounted value. Details may be found in the Choices for Care Moderate Needs Program Manual.

(iii.) SSI Eligibility Rules:

If there is a question about whether or not resources or income are countable under this section, DAIL shall apply the SSI-related community Medicaid financial eligibility rules under HBEE.

(iv.) Post-eligibility rules related to transfer of assets and patient share shall not apply to individuals enrolled in the Moderate Needs Group.

7.102.6 Wait Lists

(a) Highest Needs Group: Enrollment in the Highest Needs Group shall not be subject to a wait list.

(b) High Needs Group:

(1) Enrollment in the High Needs Group shall be limited by the availability of funds as appropriated by the Vermont Legislature.

(2) If funds are unavailable, the names of eligible applicants shall be put on a waiting list. Applicants on a waiting list shall be admitted to the Choices for Care program as funds become available, according to procedures established by the DAIL and implemented by regional Choices for Care teams. The Choices for Care teams shall use professional judgment in managing the wait list and admitting applicants with the most pressing needs. The teams shall consider the following factors:

(i.) Unmet needs for ADL assistance,

(ii.) Unmet needs for IADL assistance,

(iii.) Behavioral symptoms,

(iv.) Cognitive functioning,

(v.) Formal support services,

(vi.) Informal supports,

(vii.) Date of application,

(viii.) Need for admission to or continued stay in a nursing facility,

(ix.) Other risk factors, including evidence of emergency need, and

(x.) Priority score.

(3) Individuals whose names are placed on a wait list shall be sent written notice that their name has been placed on the list, which shall include information about how the wait list operates.

(4) When an applicant's circumstances present a clear emergency, and DAIL staff is unavailable, the individual may be admitted to services without prior approval from the DAIL. Under these circumstances, DAIL staff shall complete a retrospective review to determine eligibility. Individuals who are determined not to be eligible may be responsible for the costs of services that have been received.

(5) All active program participants who meet the High Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria

(6) Participants who are enrolled in the Highest Needs group and subsequently meet the High Needs group eligibility criteria shall be enrolled in the High Needs group and continue to be eligible to receive services.

(7) DAIL staff shall review the status of eligible applicants whose names have been on the waiting list for sixty (60) days to ensure that the applicant's needs have not changed.

(8) Any eligible applicant whose name has been on the waiting list for 60 days or more shall be given priority for enrollment over eligible applicants with similar needs whose names have been on the waiting list for a shorter amount of time.

(c) Moderate Needs Group:

(1) Enrollment in the Moderate Needs group shall be limited by the availability of funds as appropriated by the Vermont Legislature.

(2) If funds are unavailable at the local Moderate Needs provider of services, the names of any eligible applicants shall be put on a waiting list by the applicable Moderate Needs provider.

(3) Applicants on a waiting list shall be admitted to services using a priority system that utilizes the applicant's assessed risk factors as established by the DAIL in policy and procedures. Applicants who are categorically eligible for traditional Medicaid shall receive priority for purposes of enrollment.

7.102.7 Qualified Providers

(a) All Choices for Care providers must be pre-approved by the DAIL and shall abide by applicable laws, regulations, policies and procedures. The DAIL may terminate the provider status of an agency, organization, or individual that fails to do so. Choices for Care provider enrollment information may be found on the Adult Services Division website.

(b) All Choices for Care (CFC) provider agencies shall comply with all program standards, including the Universal Provider Standards, as well as program limitations as set forth in the program manual. This includes compliance with

federal Home and Community-Based Services (HCBS) regulations regarding person-centered planning, conflict of interest and setting requirements (42 CFR § 441 Subpart G).

(c) All CFC provider agencies must participate in quality management activities as defined by DAIL.

7.102.8 Authorization Requirements

(a) Eligibility Notification: All eligible applicants will receive a Notice of Decision from the Department of Vermont Health Access (DVHA) that communicates the financial, non-financial, and categorical eligibility for Medicaid and program eligibility for Choices for Care. Rules governing notices are fully set forth in Health Care Administrative Rule (HCAR) 8.100

(b) DAIL Service Authorization: All eligible participants (excluding nursing facility) will receive a notice from DAIL authorizing the amount of services and start dates. The DAIL notification will include:

(1) The basis for the decision;

(2) The legal authority for the decision;

(3) The right to request a variance;

(4) The right to appeal; and

(5) Information on how to file an appeal.

(c) Variances: The DAIL may grant variances to these regulations.

(1) Variances may be granted upon determination that the variance will otherwise meet the goals of the Choices for Care waiver and the variance is necessary to protect or maintain the health, safety or welfare of the individual.

(2) The need for a variance must be documented and the documentation presented at the time of the variance request.

(3) Applicants, participants, and providers may submit requests for a variance to DAIL at any time. Variance requests shall be submitted in writing, and shall include:

(A) A description of the individual's specific unmet need(s);

(B) An explanation of why the unmet need(s) cannot be met; and

(C) A description of the actual/immediate risk posed to the individual's health, safety or welfare.

(4) In making a decision regarding a variance request, DAIL may require further information and documentation to be submitted. DAIL also may require an in-home visit by DAIL staff. DAIL shall review a variance request and forward a decision to the individual, his or her authorized representative, if applicable, and to the provider(s). DAIL shall make a decision regarding a variance request within 30 days of receiving the request and shall send written notice of the decision, with appeal rights, within thirty (30) days.

(5) Retroactive Requests: Approved variances are effective no earlier than the date the request was received at DAIL. Retroactive requests will be considered only when a precipitating event necessitated an immediate increase of services exceeding the currently approved volume of services. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility admission. Retroactive requests must be submitted to DAIL in accordance with DAIL policy and procedure.

7.102.9 Terminations

(a) A participant may voluntarily withdraw from the Choices for Care program at any time for any reason.

(b) The State may terminate an individual's enrollment from the Choices for Care program for the following reasons:

(1) Clinical ineligibility;

(2) Medicaid financial, non-financial, and categorical ineligibility;

(3) Participant death;

(4) Stay out of state-exceeding 30 continuous days; or

(5) The participant not utilizing any of their Choices for Care services for more than 90 consecutive calendar days.

(c) In limited situations, a CFC provider may terminate or reduce, a service for one or more of the following reasons:

(1) Non-payment of patient share by the individual or authorized representative;

(2) The participant has requested that the service(s) be discontinued;

(3) The participant has moved out of the provider's designated service area;

(4) The participant chooses another provider;

(5) The participant, primary caregiver or other person in the home has exhibited behavior, including, but not limited to, physical abuse, sexual harassment, verbal threats or abuse or threatening behavior that poses a safety risk to agency staff; or

(6) The provider no longer provides the service(s) or discontinues operation.

Prior to termination of services, the provider must consult with DAIL program staff. Once a decision has been made to terminate services, the provider must notify the participant in writing according to section 7.102.11. Services may resume if the reason for termination of services has been remedied and the participant wishes to continue services.

7.102.10 Limitations

(a) Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to Medicare, Medicaid and private insurance coverage.

(b) Individuals whose only need for services is due to developmental disability or mental illness shall not be eligible for Choices for Care services.

7.102.11 Appeals, Grievances and Fair Hearings

(a) When decisions are made by the Medicaid program:

(1) The responsibilities of the Vermont Medicaid Program concerning the grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Choices for Care services are set forth in the Health Care Administrative Rule (HCAR) 8.100. The rule also sets forth requirements for Notices of an Adverse Benefit Determination, continuing services pending appeal and potential beneficiary liability, and responsibilities regarding State fair hearings.

(2) For rules that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical and clinical eligibility for Choices for Care, refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action.

(b) When decisions are made by a provider to terminate or reduce services:

(1) Designated Home Health Agencies must follow the Vermont Designation rules with regards to notification, continuation of services and appeal rights.

(2) Enhanced Residential Care Home providers and Nursing Facilities must follow the applicable Vermont licensing regulations with regards to notification, continuation of services and appeal rights.

(3) All other providers must send a written notice to the individual containing the reasons for the action, the effective date of the action, the right to continuation of services, and appeal rights. Requirements for the timing and content of provider notices may be found in the Choices for Care program manuals.

7.102.12 Quality Assurance and Improvement

(a) The State shall maintain a quality management system that complies with Global Commitment federal Terms and Conditions and Comprehensive Quality Strategy.

(b) The quality management system shall include elements of discovery, remediation, and improvement.

(c) The quality management system shall align with federal requirements.

(d) The system shall include, but is not limited to, the following:

(1) Methods of ensuring the individual’s health and welfare.

(2) An Ombudsman program that addresses the needs of participants in all settings.

(3) A process for receiving and responding to complaints.

(4) A process for receiving feedback from service participants and family members.

(5) A process for monitoring provider performance, including incident reports.

(6) A process for responding to suspicions of fraud.

(7) A process for ensuring that suspected abuse, neglect and exploitation is reported and addressed.

(e) Service providers shall comply with the requirements of the quality management system, including survey and certification procedures established by the State.