VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Commissioner's Office
280 State Drive
HC 2 South
Waterbury VT 05671-2020
Voice (802) 241-2401
Fax (802) 241-0386

August 14, 2019

Louise Corliss
Office of the Secretary of State
1078 US Route 2
Middlesex, VT 05602

Re: *Choices for Care*; Agency of Human Services, Department of Disabilities, Aging and Independent Living (DAIL)

Dear Ms. Corliss,

Attached please find a proposed amendment to the existing *Choices for Care 1115 Long-Term Care Medicaid Waiver Regulations*. The proposed rule aligns with federal and state guidance and law, improves clarity, and makes technical corrections, as well as substantive changes, which include:

- the elimination of unnecessary definitions from the existing rule;
- minor changes to covered services;
- the incorporation of program standards as set forth in the existing program manual;
- the provision of a priority/risk-based waiting list for Moderate Needs Group participants; and
- grievance and appeals language.

The Interagency Committee on Administrative Rules (ICAR) reviewed and approved the proposed rule during its meeting on August 9, 2019, subject to the Department making the recommended changes detailed in the minutes from that meeting. Those changes have been made.

Attached hereto are the following documents:

1. Administrative Procedures – Proposed Rule Filing;
2. Administrative Procedures – Adopting Page;
3. Administrative Procedures – Economic Impact Analysis;
4. Administrative Procedures – Environmental Impact Analysis;
5. Administrative Procedures – Public Input;
6. Clean text of the *Choices for Care* rule;
7. Annotated text of the *Choices for Care* rule; and
8. ICAR Minutes from August 9, 2019, meeting.

Public hearings are scheduled to be held on October 4, 2019 at the Waterbury State Office Complex. The public comment period will remain open until October 11, 2019.

Thank you for your assistance in this matter. Please do not hesitate to contact me if you have any questions or comments.

Sincerely,

Stuart G. Schurr
General Counsel

Enclosures

cc: Megan Tierney-Ward, DAIL

Administrative Procedures – Proposed Rule Filing

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" (CVR 04-000-001) adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms requiring a signature shall be original signatures of the appropriate adopting authority or authorized person, and all filings are to be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Choices for Care

_____, on 8/13/19
(signature) (date)

Printed Name and Title:
Martha Maksym, Interim Secretary, Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Filing Confirmed

1. TITLE OF RULE FILING:
   Choices for Care
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Megan Tierney-Ward

   Agency: Agency of Human Services; Department of Disabilities, Aging & Independent Living, Adult Services Division

   Mailing Address: 280 State Drive, HC 2 South Waterbury, VT 05671-0270

   Telephone: 802 241 - 0294 Fax: 802 241 - 0308

   E-Mail: megan.tierney-ward@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*:
   http://humanservices.vermont.gov/on-line-rules
4. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Stuart G. Schurr, Esq.

   Agency: Agency of Human Services; Department of Disabilities, Aging & Independent Living, Commissioner's Office

   Mailing Address: HC 2 South, 280 State Drive, Waterbury, VT 05671-2020

   Telephone: 802 241 - 0353 Fax: 802 241 - 0386

   E-Mail: stuart.schurr@vermont.gov
5. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE EXEMPTING IT FROM INSPECTION AND COPYING?) No

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:
6. LEGAL AUTHORITY / ENABLING LEGISLATION:

(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

3 V.S.A. § 801(b)(11); 33 V.S.A. § 1901(a)(1)

7. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:

AHS's authority to adopt rules, as identified above, includes, by necessity, authority to amend those rules to ensure continued alignment with federal and state guidance and law. The statutes authorize AHS as the adopting authority for administrative procedures and afford rulemaking authority for the administration of Vermont's medical assistance programs under Title XIX (Medicaid) of the Social Security Act.

8. CONCISE SUMMARY **(150 WORDS OR LESS)**:

The proposed rule sets forth the criteria for Medicaid coverage and reimbursement for Choices for Care services under Vermont's Medicaid program. It revises and will replace the current Choices for Care 1115 Long-term Care Medicaid Waiver Regulations. The rule will be adopted and incorporated into the Health Care Administrative Rules, which are designed to improve public accessibility and comprehension of the numerous rules concerning the operation of Vermont's Medicaid program.

9. EXPLANATION OF WHY THE RULE IS NECESSARY:

The rule is necessary to define coverage for Choices for Care services. This amendment aligns with federal and state guidance and law, improves clarity, and makes technical corrections. Substantive revisions include: the elimination of unnecessary definitions, changes to covered services, the incorporation of standards and language from the current program manual, and new grievance and appeals language.

10. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The rules are required to implement state and federal health care guidance and laws. Additionally, the rules are within the authority of the Secretary, are within the expertise of AHS, and are based on relevant factors including consideration of how the rules affect the people and entities listed below.

11. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Medicaid beneficiaries, Agency of Human Services, including its departments; home health agencies; area agencies on aging; adult day providers; Adult Family Care authorized agencies; Disability Rights Vermont; Vermont Center for Independent Living; Vermont Health Care Association; ARIS Solutions; Transition II; and the Long-Term Care Ombudsman Program

12. BRIEF SUMMARY OF ECONOMIC IMPACT **(150 WORDS OR LESS)**:

AHS has analyzed and evaluated the economic impact of this rule, and the rule neither increases nor reduces an economic burden on any person or entity. The only additional costs are related to a planned increase in the cap for Moderate Needs case management from 12 to 24 hours per calendar year. This increase has been approved by AHS and will be covered under the Choices for Care SFY19 year-end savings, estimated at $263,065.00. The increase in the cap for Moderate Needs case management services will provide participants with a more appropriate level of support to meet their identified needs.

13. A HEARING IS SCHEDULED .

14. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION NEEDED FOR THE NOTICE OF RULEMAKING.

Date: 10/04/2019

Time: 10:00 AM

Street Address: Waterbury State Office Complex, Oak Conference Room, 280 State Drive, Waterbury, VT

Zip Code: 05671

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

15. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING): 10/11/2019

16. KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

Medicaid

Health Care Administrative Rules

HCAR

Choices for Care

Eligibility

Covered Services

Administrative Procedures – Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Choices for Care
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):

   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment as long as the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):

   SOS Log # 09-003, Choices for Care; 1115 Long-Term Care Medicaid Waiver Regulations, Effective February 9, 2009.

Administrative Procedures – Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

1. TITLE OF RULE FILING:

   Choices for Care

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Those potentially affected by the adoption of this rule include: Medicaid beneficiaries, Agency of Human Services, including its departments; home health agencies; area agencies on aging; adult day providers; Adult Family Care authorized agencies; Disability Rights Vermont; Vermont Center for Independent Living; Vermont Health Care Association; ARIS Solutions;

Transition II; and the Long-Term Care Ombudsman Program.

The only additional costs are related to a planned increase in the cap for Moderate Needs case management services from 12 to 24 hours per calendar year. This increase has been approved by AHS and will be covered under the Choices for Care SFY19 year-end savings, estimated at $263,065.00. Increasing the Moderate Needs case management services will provide participants with a more appropriate level of support to meet their identified needs, which, in turn, increases the potential for successful consumer outcomes. When consumers have good outcomes (e.g. the right services are delivered at the appropriate level and monitored on a regular basis), the chances of preventing negative, more costly, outcomes increases.

4. IMPACT ON SCHOOLS:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

Not applicable.

6. IMPACT ON SMALL BUSINESSES:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

No impact.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

Not applicable.

8. COMPARISON:
COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
There are no alternatives to the adoption of the rule;

it is necessary to ensure continued alignment with federal and state guidance and law for covered services and benefits within Vermont's Medicaid program. The failure to increase the cap for Moderate Needs case management services could increase the chances of negative, more costly, outcomes to consumers.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ECONOMIC IMPACT ANALYSIS.*
AHS has analyzed and evaluated the anticipated costs to be expected from the adoption of this rule. The only additional costs are related to a planned increase in the cap for Moderate Needs Case Management from 12 to 24 hours per calendar year. This increase has been approved by AHS and will be covered under the Choices for Care SFY19 year-end savings, estimated at $263,065.00. The increase in the cap for Moderate Needs case management services will provide participants with a more appropriate level of support to meet their identified needs. The rule is necessary to ensure continued alignment with federal and state guidance and law for covered services and benefits within Vermont's Medicaid program.

Administrative Procedures – Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

1. TITLE OF RULE FILING:

   Choices for Care

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   No impact.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ENVIRONMENTAL IMPACT ANALYSIS.*
   This rule has no impact on the environment.

Administrative Procedures – Public Input

Instructions:

In completing the public input statement, an agency describes the strategy prescribed by ICAR to maximize public input, what it did do, or will do to comply with that plan to maximize the involvement of the public in the development of the rule.

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Choices for Care

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. PLEASE DESCRIBE THE STRATEGY PRESCRIBED BY ICAR TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE:

   The ICAR hearing was held on August 9, 2019. ICAR prescribed that AHS maximize public involvement by completing the public rulemaking process, including holding a public hearing and considering public comments that are received.

   The proposed rule will be posted on the AHS website for public comment, and a public hearing will be held on October 4, 2019.

4. PLEASE LIST THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   On March 15, 2019, AHS shared the proposed rule with, and requested feedback from, home health agencies; area agencies on aging; adult day providers; Adult Family Care authorized agencies; Disability Rights Vermont; Vermont Center for Independent Living; Vermont Health Care Association; ARIS Solutions; Transition II; and the Long-Term Care Ombudsman Program at Vermont Legal Aid, Inc. AHS received comments from the adult day providers, the VNAs of Vermont, and Vermont Legal Aid, Inc. AHS reviewed and considered these comments in drafting this proposed rule.

The proposed rule will be posted on the AHS website for public comment, and a public hearing will be held on October 4, 2019.

When the rule is filed with the Office of the Secretary of State, AHS provides notice and access to the rule through the Global Commitment Register. The Global Commitment Register provides notification of policy changes and clarifications of existing Medicaid policy, including rulemaking, under Vermont's 1115 Global Commitment to Health waiver. Anyone can subscribe to the Global Commitment Register. The proposed, final proposed, and adopted rules and all public comments and responses to this rulemaking will be posted on the Register on the Agency of Human Services website. Subscribers receive email notification of rule filings including hyperlinks to posted documents and an explanation of how to provide comment and be involved in the rulemaking.

5. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Agency of Human Services, the Department of Vermont Health Access, and the Department of Disabilities, Aging and Independent Living (DAIL);

DAIL Advisory Board;

Home Health agencies;

Adult Day programs;

Adult Family Care authorized agencies;

Disability Rights Vermont;

Vermont Center for Independent Living;

Vermont Health Care Association;

ARIS Solutions;

Transition II; and

Vermont Legal Aid, including the Long-Term Care Ombudsman Program

Choices for Care

7.102.1 Choices for Care Purpose and Scope (XX/XX/2019, GCR 19-XXX)

(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 similar state-licensed facility that has been approved by the DAIL to provide these services.

(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 a caregiver provided weight-bearing support (the caregiver needed to lift or pick up limbs, or the caregiver needed to bend legs to support the individual's weight) three or more times in the last seven days. "Total" assistance may have been provided three or more times in last seven days but not for all 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 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 a caregiver helped the applicant/participant with all parts of an ADL task each time the activity occurred during the previous seven-day period.

(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	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	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 modifications, community participation in a shared living setting.	High/Highest Needs	Up to the bundled daily tier rate on file based on 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) Financial, Non-Financial, and Categorical Eligibility

(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.

(ii.) 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.

(iii.) 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:

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

(1) 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.

(2) 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.

(3) 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.

(4) 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

(5) 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.

(6) 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.

(7) 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:

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

(1) 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.

(2) 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.

7.102.7 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 service volume and start dates. The DAIL notification will include:
NOTE: Added this per VLA feedback.

(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.

(D) 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.

7.102.8 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;
(5) The participant no longer requires Choices for Care services to remain in setting of choice.

(E) 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, and the behavior presents an imminent risk of harm to agency staff; however, services shall resume if the imminent risk of harm is remediated;
(6) Involuntary move from an Adult Family Care home (AFC); or
(7) 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 7.102.9. Services may resume if the reason for termination of services has been remedied and the participant wishes to continue services.

If a provider has terminated services, the situation is not remedied after 30 continuous days, and other CFC services are not being successfully utilized, the individual may be terminated from CFC with appeal rights.

7.102.9 Non-Covered Services

(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 primary need for services is due to developmental disability or mental illness shall not be eligible for Choices for Care services.

7.102.10 Appeals, Grievances and Fair Hearings

(a) When decisions are made by the Medicaid program:
(1) Rules governing internal appeals and State fair hearings on Medicaid services are fully set forth in Health Care Administrative Rule (HCAR) 8.100.
(2) Rules governing fair hearings and expedited administrative appeals regarding eligibility determinations are fully set forth in Health Benefit Eligibility and Enrollment (HBEE) Rules Part 8.

(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.

(c) Rules governing grievances are fully set forth in Health Care Administrative Rule (HCAR) 8.100.

7.102.11 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.

CHOICES FOR CARE

1115 Long-term Care
Medicaid Waiver Regulations

STATE OF VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
DIVISION OF DISABILITY AND AGING SERVICES

Effective February 9, 2009

~~For additional information, or to obtain copies of these regulations in this or other formats, contact:~~

~~**The Division of Disability and Aging Services**~~
~~**Department of Disabilities, Aging and Independent Living**~~

~~103 South Main Street Waterbury, VT 05671-1601~~
~~Phone: 802-241-2400~~
~~Fax: 802-241-4224~~
~~www.dail.state.vt.us~~

CHOICES FOR CARE
1115 Long-term Care Medicaid Waiver Regulations

Table of Contents

CHOICES FOR CARE
1115 Long-term Care Medicaid Waiver Regulations

I. Purpose and Scope

A. The "Choices for Care" Medicaid waiver operates as a Research and Demonstration Project authorized under Section 1115(a) of the Social Security Act. This program provides long-term care services to elderly or physically disabled Vermont adults who are found eligible by the Department of Disabilities, Aging and Independent Living (the Department or DAIL). The primary goal of the Choices for Care waiver is to provide Vermonters with equal access to either nursing facility care or home and community-based services, consistent with their choice. The Choices for Care waiver 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.

B. The Choices for Care waiver shall serve the following long-term care financial eligibility groups as defined in Vermont Medicaid regulations:

- Categorically eligible individuals
- Medically needy individuals
- Medicaid Working Disabled

C. If an individual selects the Program for All-Inclusive Care for the Elderly (PACE), the regulations and procedures governing the administration of the PACE program will apply.

II. General Policies

A. Long-term care 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. Long-term care services shall be provided in a cost-effective and efficient manner, preventing duplication, unnecessary costs, and unnecessary administrative tasks. The Department shall manage long-term care services so as to use resources efficiently and to maximize the benefits and services available to the greatest number of eligible individuals.

C. The Department shall administer the Choices for Care waiver in accordance with these regulations, the CMS terms and conditions, and applicable state and federal law.

D. Eligible individuals shall be informed of feasible service alternatives.

E. Consistent with federal terms and conditions, the Department has the authority to implement different elements of the Choices for Care waiver at different times.

F. The Department encourages any applicant or participant who disagrees with a decision to contact the Department staff person who made the decision to try to resolve the disagreement informally.

III. Definitions

The following definitions shall be used for these regulations and in the administration of the Choices for Care Medicaid waiver:

1. "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.
2. "Adult Day Services" means a range of health and social services provided at a certified adult day site.
3. "Adult Foster Care" means care and supervision provided by an approved provider, limited to a maximum of two individuals in each setting.
4. "Applicant" means an individual who has submitted an application to the Department.
5. "Assistive Devices" means devices used to increase, maintain, or improve the individual's functional capabilities.
6. "Authorized Representative" means an individual who has been given legal authority to act on behalf of an applicant or participant.
7. "Behavioral Symptoms" means behavior that is severe, frequent and requires a controlled environment to provide continuous monitoring or supervision.
8. "Case Management" means assistance to individuals in gaining access to services, regardless of the funding source. Case management includes individual assessment, service planning, and monitoring of services.
9. "Cash and Counseling" means a service model through which an individual is given greater choice in how long-term care funds are spent to meet individual needs.
10. "Commissioner" means the Commissioner of the Department of Disabilities, Aging and Independent Living.
11. "Companion Care" means supervision and socialization of individuals who are unable to care for themselves, as required by the needs of the individual (e.g. protective supervision, assistance with transportation, recreation, etc.).
12. "Controlled Environment" means an environment that provides continuous care and supervision.
13. "Date of Application" means the date that an application is received by the Department.
14. "Department" means the Department of Disabilities, Aging and Independent Living.
15. "Elderly" means individuals age 65 and over.
16. "Eligible Groups" means the groups of people who are found to meet the eligibility criteria for the Highest, High, or Moderate Needs groups.
17. "Eligibility Screening" means the process used to determine if people are eligible for Choices for Care.

18."Emergency" means circumstances that present a clear and imminent risk of irreparable harm or death.
19."Enhanced Residential Care" means a package of services provided to individuals residing in a licensed Residential Care Home that has been approved to provide these services.
20."Enrolled" means that a person has been found eligible, has been assigned to an eligibility group, and is authorized to receive services.
21."Feasible Service Alternatives" means service options that are available and can reasonably be expected to meet an individual's needs.
22."High Needs Group" means those individuals who have been found to meet the high needs group eligibility criteria and have been authorized to receive services.
23."Highest Needs Group" means those individuals who have been found to meet the highest needs group eligibility criteria and have been authorized to receive services.
24."Home and Community-Based Services" means all long-term care services provided under these regulations, with the exception of nursing facility care.
25."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.
26."Homemaker Services" means home-based services such as shopping, cleaning, and laundry provided to help people live at home in a healthy and safe environment.
27. "Informed Consent" means a process by which an individual or an individual's legal representative 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.
28."Instrumental Activities of Daily Living" (IADLs) means meal preparation, medication management, phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment.
29."Intermediary Services Organization" means an organization that provides assistance to individuals with payroll, taxes, and other financial management tasks.
30."Legal Representative" means a court-appointed guardian or an agent acting under a durable power of attorney, if the power to make the relevant decision is specified in the terms of the appointment or power of attorney
31."Long-Term Care Services" means those services covered by the Choices for Care 1115 Medicaid Waiver as described in these regulations.
32."Moderate Needs Group" means those individuals who have been found to meet the Moderate Needs group eligibility criteria and who have been authorized to receive services.
33."Negotiated Risk" means a process of negotiation and selection of services that respects the participant's preferences, choices, and capabilities while allowing the participant to choose service options and to accept the reasonable risk for the consequences of those decisions.
34. "Participant" means an individual for whom services have been authorized in accordance with these regulations.
35."PASARR" means "Pre-Admission Screening and Annual Resident Review" that is used to identify a need for active treatment due to a mental illness or mental retardation.

36."Person-Centered Planning" means a process by which services are planned and delivered, based on an individual's strengths, capacities, preferences, needs, and desired outcomes.
37."Personal Care" means assistance to individuals with ADLs and IADLs that is essential to the individual's health and welfare.
38."Personal Emergency Response Systems (PERS)" means electronic devices that enable individuals to secure help in an emergency.
39."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.
40."Program for All-Inclusive Care for the Elderly (PACE)" means a combination of medical, acute, and long-term care services provided to individuals aged 55 and over by an approved PACE provider.
41."Provider" means any individual, organization, or agency that has been authorized by the Department to provide Medicaid Choices for Care waiver services.
42."Provider Qualifications" means the requirements established by the Department for providers of specific services, including any regulations pertaining to each provider.
43. "Reimbursement" means payment made to a provider for the provisions of services, including any special rates established by the Department.
44."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).
45."Respite Care" means relief from caregiving and supervision for primary caregivers.
46."Service Definition" means the formal definition established by the Department for reimbursement of specific services.
47."Service Plan" means a written document by which services are authorized and which guides the delivery of services.
48."Service Standards" means the requirements established by the Department for the delivery of specific services.
49."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.
50."Variance" means an exception to or exemption from these regulations granted by the Department as allowed under applicable statute and regulation.
51."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.
52."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.

IV. Eligibility

A. Standards for Eligibility

1. An eligible individual must be a Vermont resident aged 18 or older who meets both clinical and financial eligibility criteria.

2. Choices for Care shall not replace or supplant services otherwise provided under other 1915c Medicaid waivers or other 1115 Medicaid waivers (e. g. Community Rehabilitation and Treatment). Thus, to be eligible for services other than nursing facility services, an individual must have a functional physical limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging. Individuals whose need for services is due to mental retardation, autism, or mental illness shall not be eligible for services.

3. 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 private insurance, Medicaid and Medicare.

B. Clinical Eligibility Criteria

The Department shall determine whether an applicant or participant is eligible under any of three categories:

1. Highest Needs Group

a. Individuals shall receive eligibility screening (including PASARR screening, as appropriate) as the initial step in eligibility determination for the Highest Needs group.

b. Individuals who apply and meet any of the following eligibility criteria shall be eligible for and enrolled in the Highest Needs group:

i. Individuals who require 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. Individuals who have a 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 Symptoms

iii. Individuals who have 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. Individuals who have 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

c. The Department shall enroll an individual in the Highest Needs group when the Department 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. The Department may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

i. Loss of primary caregiver (e. g. hospitalization of spouse, death of spouse);
ii. Loss of living situation (e. g. fire, flood);
iii. 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
iv. 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.).

d. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, meet any of these Highest Needs eligibility criteria shall be enrolled in the Highest Needs group.

e. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

2. High Needs Group

a. Individuals shall receive eligibility screening (including PASARR screening, as appropriate) as the initial step in eligibility determination for the high needs group.

b. Individuals who meet any of the following eligibility criteria shall be eligible for the High Needs group and may be enrolled in the High Needs group:

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 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

AND who require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a daily basis.

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

vii. Individuals whose health and welfare shall be at imminent risk if services are not provided or if services are discontinued.

c. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, do not meet Highest Needs eligibility criteria but do meet any of these High Needs eligibility criteria shall be enrolled in the High Needs group.

d. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

3. Moderate Needs Group

a. Individuals shall receive eligibility screening as the initial step in eligibility determination for the Moderate Needs group.

b. Individuals who meet any of the following eligibility criteria shall be eligible for the Moderate Needs group and may be enrolled in the Moderate Needs group:

i. Individuals who require supervision or any physical assistance three (3) or more times in seven (7) 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. Individuals whose health condition shall worsen if services are not provided or if services are discontinued.

C. Clinical Eligibility for Current Long-Term Care Medicaid Recipients

All individuals who are currently being served under a preexisting 1915c Medicaid Waiver (Home-Based or Enhanced Residential Care) or who are receiving Medicaid nursing facility care at the time of the implementation of the Choices for Care waiver shall be enrolled in the Choices for Care waiver and shall continue to receive services. Thereafter, these participants shall continue to be enrolled in Choices for Care if, at reassessment, they meet the eligibility criteria for the Highest Needs group, the High Needs group or the Guidelines for Nursing Home Eligibility adopted in April of 1997.

D. Financial (Medicaid) Eligibility Standards

1. Highest Needs Group and High Needs Group

The Department for Children and Families (DCF) shall determine eligibility for applicants for the Highest and High Needs groups according to DCF Supplemental Security Income (SSI)-related Medicaid regulations applicable to long-term care eligibility.

2. Moderate Needs Group

The Department for Disabilities, Aging and Independent Living (the Department) shall find individuals financially eligible for the Moderate Needs group if they meet the criteria below. Individuals who meet the financial and clinical eligibility requirements shall be enrolled in the Moderate Needs group according to the enrollment process specified in these regulations. Post-eligibility rules related to transfer of assets and patient share shall not apply to individuals enrolled in the Moderate Needs group.

a. Income

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, unearned.

ii. Income Eligibility Standard: 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 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).

b. Resources

i. Countable Resources: Countable resources includes 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.

ii. Resource Eligibility Standard: The resource standard is met when all resources are less than or equal to $10,000. If the resources exceed $10,000, the individual shall not be eligible.

c. SSI Eligibility Rules

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

V. Initial Application Process

A. Application Process: Individuals who wish to enroll in the Choices for Care Medicaid Waiver shall complete an application and file it with Department or with the Department's clinical coordinators in the district offices. If an application is filed in the Department's central office, it shall be conveyed to the appropriate clinical coordinator as soon as possible.

B. Application: The application for Choices for Care shall consist of the Department's application form related to clinical eligibility and the Department for Children and Families (DCF)'s long-term care Medicaid application form. The applicant may submit the two application forms at the same time or may submit them separately. The date of application for purposes of home-base long-term care Medicaid eligibility and retroactive coverage shall be the date the DCF long-term care application is received by DCF and shall begin no sooner than the date both clinical and financial eligibility are met. If the applicant does not receive community Medicaid but may be eligible for it, the Department shall forward the application to DCF in order to process the applicant's eligibility for community Medicaid. Community Medicaid eligibility and retroactive coverage shall be determined according to DCF rules, and the date of application shall be the date the DCF financial eligibility application is received by DCF.

C. Initial Screening: Department staff shall screen application forms for missing/incomplete information. Department staff shall contact the individual, the referral source, or both, to gather additional information as needed.

D. Clinical Assessment: Department staff shall determine clinical eligibility and category (Highest or High Needs group) from assessment information submitted with the application and, if needed, from a face-to-face review.

1. Highest Needs Group: All individuals who apply and meet both the clinical criteria for Highest Need and the financial criteria for Long-term Care (LTC) Medicaid services shall be enrolled in the program. Active program participants who meet the Highest Needs group clinical criteria at reassessment shall not be

terminated from services, provided that they continue to meet all other eligibility criteria.

2. High Needs Group: Enrollment in the High Needs group shall be limited by the availability of funds. Individuals who apply and meet both the clinical criteria for the High Needs group and the financial criteria for Long-term Care (LTC) Medicaid services may be enrolled in the program.

a. 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 waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care waiver teams shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals 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.

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

c. When an individual's circumstances present a clear emergency, and Department staff is unavailable, the individual may be admitted to services without prior approval from the Department. Under these circumstances, Department 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.

d. 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. Individuals who are enrolled in the Highest Needs group and subsequently fail to meet the eligibility criteria for the Highest Needs group, but meet the High Needs group eligibility criteria, shall be enrolled in the High Needs group and continue to be eligible to receive services.

e. Department 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.

f. 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.

3. Moderate Needs Group: Enrollment in the Moderate Needs group shall be limited by the availability of funds. Applicants who meet both the clinical criteria and the financial criteria for the Moderate Needs group may be enrolled in the program. If funds are unavailable, the names of any eligible applicants shall be put on a waiting list. Applicants on a waiting list shall be admitted on a first-come, first- served basis, by date that the application is received, as funds become available. Individuals who are categorically eligible for traditional Medicaid shall receive priority access to the Moderate Needs group, based on the date that the application is received. Individuals who are not categorically eligible for traditional Medicaid shall be admitted as a second priority.

E. Financial Assessment: If the individual meets the Highest Need group clinical criteria, or meets the High Need clinical criteria and funds are available, Department staff will supply the individual with a DCF Long-Term Care Medicaid financial eligibility form if needed.

F. The Department shall make a decision regarding clinical eligibility for Choices for Care within 30 days of receiving the application.

G. Notifications: If the applicant is found clinically eligible for the Highest Needs group, or the High Needs group with funds available, DAIL staff will send a Clinical Certification notice to DCF and Choices for Care provider(s). DCF staff will then complete the Long-Term Care Medicaid financial eligibility process. If the applicant is found ineligible, DAIL staff shall send a written notice with appeal rights as set forth in the notice section below.

H. Final Authorization: When financial eligibility is determined, DCF staff will notify the Department, the applicant and the highest paid provider (if a patient share is due). If the applicant is found eligible, Department staff will authorize services and send notification to the individual and providers. Department staff will complete and send a copy of the transitional service plan to the individual.

VI. Continued Eligibility Process

A. Screening: Department staff will screen reassessment and plan of care forms for missing or incomplete information. Department staff will contact the case manager or individual to gather additional information, as needed.

B. Clinical Re-Assessment: Department staff will determine clinical eligibility and category (Highest Needs group or High Needs group) from assessment information submitted with the continued eligibility materials. A face-to-face review may be completed as necessary.

1. Highest Needs Group: Active program participants who meet the Highest Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria.

2. High Needs Group: 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. Individuals who are enrolled in the Highest Needs group and subsequently fail to meet the eligibility criteria for the Highest Needs group, but meet the High Needs group eligibility criteria, shall be enrolled in the High Needs group and continue to be eligible to receive services.

3. Moderate Needs Group: Enrollment in the Moderate Needs group shall be limited by the availability of funds. Active program participants who meet the Moderate Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria and that funds remain available.

4. Ineligible Participants: Active program participants who do not meet clinical eligibility criteria for any group shall be disenrolled and shall receive written notice of this decision with appeal rights.

C. Financial Eligibility: DCF staff shall be responsible for determining whether individuals remain eligible under Long-Term Care Medicaid financial eligibility criteria for the Highest Needs group or the High Needs group. Department staff shall be responsible for determining whether individuals remain eligible under financial eligibility criteria for the Moderate Needs group.

D. Final Authorization: Department staff shall authorize services and send written notice to the individual, the legal representative, if applicable, and the provider(s). If the participant is found to be ineligible, DAIL staff shall send a written notice with appeal rights as set forth in the notice section below.

E. Time Limit: Department staff shall make a clinical eligibility determination within 30 days of receiving application materials.

VII. Assessment Process

A. Consistent with Act 123 of the 2003-2004 Legislative Session, the Department is charged with implementing the following statewide protocols to ensure that individuals entering the long-term care system are assessed and informed of their options prior to entering a nursing facility. The protocol attempts to ensure that the assessment and information is provided in a

timely manner so as not to delay discharges from hospitals and includes provisions for emergency admissions to nursing facilities.

1. Community Applications

a. Department staff shall make information regarding long-term care service options for all individuals available to local agencies and organizations.

b. Applications may be sent to the Department from many sources, including individuals, families, service providers, community organizations and physician offices. Local agencies and organizations shall be encouraged to refer to the Department those individuals who want to apply for Choices for Care waiver services, regardless of what setting they might be interested in (home, nursing facility, or residential care).

c. Local agencies and organizations shall complete individual assessments according to their internal protocols. Local agencies shall send this assessment data and Choices for Care waiver application forms to regional Department staff in a timely manner.

d. Department staff shall make all reasonable efforts to utilize the information available from existing assessments. When possible, Department staff shall determine clinical eligibility for the Choices for Care waiver using the existing assessment data.

e. Department staff shall screen all individuals applying for long-term care services.

f. For those individuals who appear to be eligible for long-term care services, Department staff shall complete initial assessments as necessary, and shall provide initial counseling regarding long-term care options.

g. Department staff shall complete a transitional service plan for applicants who are eligible for long-term care services and choose home and community-based services.

h. When an individual's circumstances present a clear emergency, and Department staff is unavailable, he or she may be admitted to services without prior approval from the Department. Under these circumstances, the Department shall complete a retrospective review to determine eligibility. If individuals are determined to be ineligible, the Department shall not be responsible for the cost(s) of services received.

2. Applications from Hospitals and Nursing Facilities

a. Department staff shall provide facilities with information regarding long-term care service options for all individuals whom facility staff believes could benefit from receiving the information.

b. Facility staff shall provide information packets to individuals at the time of admission or as soon as possible following admission.

c. Facility staff shall refer to the Department those individuals who want to apply for Choices for Care waiver services, regardless of what setting they may be interested in (home-based, nursing facility, or enhanced residential care). Applications from hospital settings shall be made as soon as possible following admission.

d. Facility staff shall complete individual assessments according to their internal protocols.

e. Facility staff shall send the assessment data and completed Choices for Care waiver applications to Department staff in a timely manner.

f. Department staff shall make all reasonable efforts to utilize the information available from existing assessments. When possible, Department staff shall determine clinical eligibility for the Choices for Care waiver using existing assessment data.

g. After Department staff receives the completed Choices for Care waiver application and assessment information, he or she shall make reasonable efforts to assess and explain long-term care options, as necessary, to individuals prior to discharge from a hospital. If a face-to-face visit is not possible prior to discharge, Department staff shall make arrangements to see the individual as soon as possible following discharge. In no event shall the application process interfere with a hospital's ability to discharge an individual when the individual no longer needs acute care.

h. Individuals whose skilled care stay exceeds their Medicare-covered benefit must apply and be found eligible for Choices for Care waiver coverage in order to receive a nursing facility Medicaid benefit. Department regional staff shall visit the individual in the facility setting as necessary to assess the individual, determine clinical eligibility, and discuss care/support options.

i. Individuals who exhaust their private resources and any insurance coverage must apply and be found eligible for Choices for Care waiver coverage in order to receive a nursing facility Medicaid benefit.

j. When an individual's circumstances present a clear emergency, and Department staff is unavailable, he or she may be admitted to services without prior approval from the Department. Under these circumstances, the Department shall complete a retrospective review to determine eligibility. If individuals are determined to be ineligible, the Department shall not be responsible for the cost of services received.

B. Assessments and Service Plans. All individuals shall receive an initial assessment and periodic re-assessments. Participants shall be re-assessed after any significant change in circumstances or condition, or at the request of the participant, but no less than annually.

1. Reviews: Assessments shall be reviewed by the Department to determine clinical eligibility and need for services, including the type and amount of services to

be authorized. Re-assessments shall be reviewed by the Department to determine continued clinical eligibility and continued need for services, including the type and amount of services to be authorized.

2. Nursing Facility Service Plans: Nursing facilities shall develop individual service plans for all individuals in compliance with prevailing conditions of participation and licensing regulations.

3. Enhanced Residential Care Service Plans: Residential care homes and assisted living residences shall provide individualized services to all individuals, in compliance with prevailing conditions of participation and regulations. Choices for Care waiver services shall be furnished pursuant to service plans that are approved by the Department. Individuals shall receive copies of approved service plans of care, including written notices that state appeal rights and procedures. Choices for Care waiver service plans shall be approved for a maximum of twelve (12) months.

4. PACE Service Plans: PACE sites shall develop individual service plans for all participants, in compliance with conditions of participation and regulations.

5. Home and Community-Based Service Plans: Assessments shall be used to prepare appropriate service plans. An individualized written service plan shall be developed for each participant. Service plans shall be prepared using person- centered planning with the individual and his or her legal representative, if any, using an informed consent process including negotiated risk. Family members and service providers shall also be consulted, as appropriate. Service plans shall describe the Choices for Care waiver services and other services to be furnished, regardless of funding source, their frequency, and the provider who shall furnish each service. Choices for Care waiver services shall be furnished pursuant to service plans approved by the Department. Individuals shall receive copies of the approved service plans of care, including written notices that state appeal rights and procedures. Choices for Care waiver service plans shall be approved for a maximum of twelve (12) months.

6. Levels of Assistance: Individuals shall have individualized service plans that are designed to protect the individual's health and welfare. Within established service limitations, levels of assistance shall be authorized in adequate type, scope, and amount to protect the individual's health and welfare.

7. Individual Budgets: The Department may establish individual budget processes, which shall provide enrolled individuals with more flexibility in the type and amount of Choices for Care waiver services that are provided within individual financial limits.

C. Long-Term Care Options: Department staff shall discuss Choices for Care options as part of the application and assessment process. Department staff shall ensure that options brochures and information are readily available.

VIII. Services

The Department shall establish service definitions, service standards, and provider qualifications for all services and may, for the effective and efficient administration of the program, and consistent with state and federal law and federal terms and conditions, impose limitations on covered services.

A. Highest Needs Group Services

Individuals enrolled in the Highest Needs group may receive the following services, based on a service plan that is approved by the Department:

1. Case Management (maximum of 48 hours/year)
2. Personal Care (maximum of 4.5 hours/week of assistance for the following IADLs: phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment)
3. Respite Care (maximum, including companion care, of 720 hours/year)
4. Companion Care (maximum, including respite care, of 720 hours/year)
5. Adult Day Services (maximum of 12 hours/day)
6. Assistive Devices and Home Modifications (maximum of $750/year)
7. Personal Emergency Response Systems (PERS)
8. Intermediary Services Organization (ISO)
9. Enhanced Residential Care
10. Nursing Facility
11. Program for All-Inclusive Care for the Elderly (PACE) – *implementation to be phased in*
12. Adult Foster Care – *implementation to be phased in*
13. Cash and Counseling – *implementation to be phased in*
14. Other services as defined by the Department

B. High Needs Group Services

Individuals enrolled in the High Needs group may receive the following services, based on a service plan that is approved by the Department:

1. Case Management (maximum of 48 hours/year)
2. Personal Care (maximum of 4.5 hours/week of assistance for the following IADLs: phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment)
3. Respite Care (maximum, including companion care, of 720 hours/year)
4. Companion Care (maximum, including respite care, of 720 hours/year)
5. Adult Day Services (maximum of 12 hours/day)
6. Assistive Devices and Home Modifications (maximum of $750/year)
7. Personal Emergency Response Systems (PERS)
8. Intermediary Services Organization (ISO)
9. Enhanced Residential Care

10. Nursing Facility
11. Program for All-Inclusive Care for the Elderly (PACE) *– implementation to be phased in*
12. Adult Foster Care *– implementation to be phased in*
13. Cash and Counseling *– implementation to be phased in*
14. Other services as defined by the Department

C. Moderate Needs Group Services

Individuals enrolled in the Moderate Needs group may receive the following services, based on a service plan that is approved by the Department:

1. Case management (maximum of 12 hours/year)
2. Adult day services (maximum of 30 hours/week)
3. Homemaker (maximum of 6 hours/week)
4. Other services as defined by the Department

D. Transitional Service Plan:

In addition to the Clinical Certification, Department staff will create a transitional services plan identifying the Choices for Care waiver services and estimated volume of services. Providers may use this plan to start services pending Long-Term Care Medicaid Waiver financial approval. Reimbursement for services shall not occur unless and until the individual is found financially eligible.

IX. Notice

A. When the Department makes a decision regarding an applicant or participant's eligibility, type or amount of services authorized, or variance request, a written notice of the decision shall be sent.

B. The written notice of decision shall 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.

X. Provider Responsibilities

Agencies, organizations, and individuals who provide Choices for Care services shall abide by applicable laws, regulations, policies and procedures. The Department may terminate the provider status of an agency, organization, or individual that fails to do so.

XI. Variances

A. The Department may grant variances to these regulations. Variances may be granted upon determination that:

1. The variance will otherwise meet the goals of the Choices for Care waiver; and
2. The variance is necessary to protect or maintain the health, safety or welfare of the individual. The need for a variance must be documented and the documentation presented at the time of the variance request.

B. Applicants, participants, and providers may submit requests for a variance to the Department at any time.

C. Variance requests shall be submitted in writing, and shall include:

1. A description of the individual's specific unmet need(s);
2. An explanation of why the unmet need(s) cannot be met; and
3. A description of the actual/immediate risk posed to the individual's health, safety or welfare.

D. In making a decision regarding a variance request, the Department may require further information and documentation to be submitted. The Department also may require an in-home visit by Department staff. The Department shall review a variance request and forward a decision to the individual, his or her legal representative, if applicable, and to the provider(s).

E. The Department 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.

XII. Appeals

A. An individual may request a Commissioner's hearing, a fair hearing before the Human Services Board, or both. An appeal may be made to the Commissioner and the Human Services Board at the same time. An appeal may also be made to the Human Services Board following a Commissioner's hearing.

B. Commissioner's Hearing.

1. An applicant or participant, or his or her legal representative, who wishes to appeal a decision regarding clinical eligibility, termination of eligibility, the type or amount of services authorized or a variance may request a formal review of that decision by the Commissioner of the Department.

2. The request for a Commissioner's hearing may be made orally or in writing, and shall be made within 30 days of receiving written notice.

3. A request for a Commissioner's hearing shall be made by calling or writing to:

Commissioner's Office
Department of Disabilities, Aging & Independent Living 103 South Main Street
Waterbury, VT 05671
802-241-2401

4. The Commissioner shall send written notice of the decision, with appeal rights, to the applicant or participant within thirty (30) days of the completion of the hearing.

C. Fair Hearing. An applicant or participant, or his or her legal representative, may file a request for a fair hearing with the Human Services Board. An opportunity for a fair hearing will be granted to any individual requesting a hearing because his or her claim for assistance, benefits or services is denied, or is not acted upon with reasonable promptness; or because the individual is aggrieved by any other Department action affecting his or her receipt of assistance, benefits or services; or because the individual is aggrieved by Department policy as it affects his or her situation. The Department shall respond to any clear indication (oral or written) that an applicant or participant wishes to appeal by helping that person to submit a request for a hearing.

1. An applicant or participant, or his or her legal representative, who wishes to appeal a decision of the Commissioner or any decision regarding clinical eligibility, termination of eligibility, the type or amount of services authorized or a variance may request a fair hearing with the Human Services Board.

2. The request for a fair hearing must be made within ninety (90) days of receiving the written notice of determination or the written notice of the decision of the Commissioner.

3. A request for a fair hearing shall be made to: Human Services Board
120 State Street
Montpelier, VT 05620-4301
802-828-2536

D. Continuation of Services Pending Appeal

1. Long-term care services shall not be provided to new applicants during the appeals process.

2. Long-term care services may continue to be provided to enrolled participants during the appeals process.

3. In order to continue to receive services, enrolled participants must request continued services when submitting the appeal. Choices for Care services shall be discontinued on

the effective date of the decision unless the appeal is requested as of the effective date of the decision. In no event shall the effective date occur on a weekend or holiday.

4. Continuation of services does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law or rule affecting some or all participants, or when the decision does not require advance notice.

E. Adverse Action

When a Department decision will end or reduce the amount of services an individual has been receiving, the notice of decision shall be mailed at least eleven (11) days before the decision will take effect, except when:

1. The Department has facts confirming the death of the individual;

2. The Department has facts confirming that the individual has moved to another state;

3. The Department has facts confirming that the individual has been granted Medicaid in another State;

4. The individual has been admitted to a facility or program that renders the individual ineligible for services;

5. The Department receives a statement signed by an individual that states that he or she no longer wishes services; or

6. The individual's whereabouts are unknown and the post office returns agency mail directed to him or her indicating no forwarding address.

F. Financial Eligibility

Financial eligibility decisions or patient share determinations must be filed pursuant to DCF Medicaid regulations. If such an appeal is inadvertently submitted to the Department, it shall be forwarded to DCF as soon as possible.

XIII. Quality Assurance/Quality Improvement

A. The Department shall develop a quality assurance/quality improvement system that complies with federal terms and conditions.

B. The quality assurance/quality improvement system shall include elements of discovery, remediation, and improvement. 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 Medicaid long-term care 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.

C. Service providers shall comply with the requirements of the quality assurance/quality improvement system, including survey and certification procedures established by the Department.

Choices for Care

7.102.1 Choices for Care Purpose and Scope (XX/XX/2019, GCR 19-XXX)

(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 similar state-licensed facility that has been approved by the DAIL to provide these services.

(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 a caregiver provided weight-bearing support (the caregiver needed to lift or pick up limbs, or the caregiver needed to bend legs to support the individual's weight) three or more times in the last seven days. "Total" assistance may have been provided three or more times in last seven days but not for all 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 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 a caregiver helped the applicant/participant with all parts of an ADL task each time the activity occurred during the previous seven-day period.

(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	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	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	High/Highest Needs	Up to the amount of the individualized budget

	Directed Personal Care, Respite, Companion		
Adult Family Care	Case management, personal care, respite, assistive devices/home modifications, community participation in a shared living setting.	High/Highest Needs	Up to the bundled daily tier rate on file based on 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) Financial, Non-Financial, and Categorical Eligibility

(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.

(ii.) 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.

(iii.) 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:

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

(1) 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.

(2) 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.

(3) 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.

(4) 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

(5) 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.

(6) 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.

(7) 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:

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

(1) 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.

(2) 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.

7.102.7 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 service volume and start dates. The DAIL notification will include:
NOTE: Added this per VLA feedback.

(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.

(D) 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.

7.102.8 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;
(5) The participant no longer requires Choices for Care services to remain in setting of choice.

(E) 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, and the behavior presents an imminent risk of harm to agency staff; however, services shall resume if the imminent risk of harm is remediated;
(6) Involuntary move from an Adult Family Care home (AFC); or
(7) 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 7.102.9. Services may resume if the reason for termination of services has been remedied and the participant wishes to continue services.

If a provider has terminated services, the situation is not remedied after 30 continuous days, and other CFC services are not being successfully utilized, the individual may be terminated from CFC with appeal rights.

7.102.9 Non-Covered Services

(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 primary need for services is due to developmental disability or mental illness shall not be eligible for Choices for Care services.

7.102.10 Appeals, Grievances and Fair Hearings

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

(1) Rules governing internal appeals and State fair hearings on Medicaid services are fully set forth in Health Care Administrative Rule (HCAR) 8.100.
(2) Rules governing fair hearings and expedited administrative appeals regarding eligibility determinations are fully set forth in Health Benefit Eligibility and Enrollment (HBEE) Rules Part 8.

(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.

(c) Rules governing grievances are fully set forth in Health Care Administrative Rule (HCAR) 8.100.

7.102.11 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.

State of Vermont
Agency of Administration
109 State Street
Montpelier, VT 05609-0201
www.aoa.vermont.gov

[phone] 802-828-3322
[fax] 802-828-3320

Office of the Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: August 9, 2019, Pavilion Building, 5th floor conference room, 109 State Street, Montpelier, VT 05609

Members Present: Steve Knudson (Acting Chair), Ashley Berliner, John Kessler, Clare O'Shaughnessy Matt Langham, and Dirk Anderson. Diane Bothfeld and Jennifer Mojo participated via phone

Members Absent: Chair Brad Ferland

Minutes By: Melissa Mazza-Paquette

- 2:00 p.m. meeting called to order, welcome and introductions.
- Review and approval of minutes from the July 8, 2019 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- No public comments made.
- Presentation of Proposed Rules on pages 2-14 to follow.
  1. Rule 4.400, The Renewable Energy Standard Rule, Vermont Public Utility Commission, page 2
  2. Child Support Guidelines, Agency of Human Services, Department of Children and Families, Office of Child Support, page 3
  3. Business Entity Limited Lines Producer for Self-Storage Insurance License (I-2019-02), Department of Financial Regulation, page 4
  4. Choices for Care, Agency of Human Services, Department of Disabilities, Aging and Independent Living, page 5
  5. Rules of the Board of Medical Practice, Agency of Human Services, Department of Health, page 6
  6. Rules Governing Inspection of Motor Vehicles, Agency of Transportation, Department of Motor Vehicles, page 7
  7. Audiology Services, Agency of Human Services, page 8
  8. Eyewear and Vision Care Services, Agency of Human Services, page 9
  9. Dental Services for Beneficiaries Under Age 21, and Pregnant and Postpartum Women, Agency of Human Services, page 10
  10. Dental Services for Beneficiaries Age 21 and Older, Agency of Human Services, page 11
  11. Medicaid Cost Sharing, Agency of Human Services, page 12
  12. Medically Complex Nursing Services, Agency of Human Services, page 13
  13. In-Home Lactation Consultation Services, Agency of Human Services, page 14
- Next scheduled meeting is Monday, September 9, 2019 at 2:00 p.m.
- 3:15 p.m. meeting adjourned.

Proposed Rule: Choices for Care, Agency of Human Services, Department of Disabilities, Aging and Independent Living
Presented by Stuart Schurr

Motion made to accept the rule by Diane Bothfeld, seconded by Dirk Anderson, and passed unanimously except for Ashley Berliner who abstained, with the following recommendations:

1. Proposed Rule Coversheet, page 2, #6: Correct 33 V.S.A. to 3 V.S.A.
2. Proposed Rule Coversheet, page 2, #7: Correct 'Tile' to 'Title' in the second to last line.
3. Public Input, page 1, #3: Include posting on your website.