Choices for Care Regulations Summary of Changes - August 2019

The 2009 Choices for Care regulations are being revised into the new Health Care Administrative Rules (HCAR) format. The goal is to:

1. Modernize the text.
2. Eliminate unnecessary content including outdated process language that is more appropriate for the Choices for Care Policy & Procedure manuals.
3. Improve alignment with current Medicaid rules.
4. Improve clarity of terminations, grievance and appeal rights.
5. Increase the Moderate Needs Case Management services cap to 24 hours per calendar year.
6. Modify the Moderate Needs waitlist process from chronological to a priority system.

Anticipated Timeline

- ⌦ September 2018 - March 2019: Draft language into the HCAR format and first internal review by DAIL, Medicaid Policy and interested Departments.
- ⌦ March 2019 - April 2019: Informal feedback solicited from stakeholders.
- ⌦ May 2019 – July 2019: Follow up conversations with stakeholders and prepare draft rules for filing.
- ⌦ July/August 2019: File draft regulations with the Interagency Committee on Administrative Rules (ICAR).
- ⌦ August/September 2019: File regulations with Legislative Committee on Administrative Rules (LCAR). Formal 30-day public input and LCAR hearing scheduled.
- ⌦ October 4, 2019: Public Hearing at the Waterbury State Complex, Oak Conference Room, 10 a.m. - 12:30 p.m.
- ⌦ End of 2019/Early 2020: Finalize and disseminate regulations.

Summary of Draft Changes by HCAR Section

Section 7.102.1 – Choices for Care Purpose & Scope

- Modified language to reflect Choices for Care operations within Vermont's Global Commitment to Health 1115 Waiver.

Section 7.102.2 - Definitions

- Updated definitions that needed clarity or a change in terminology, without changing meaning.
- Removed unnecessary definitions that already exist in the current Medicaid rules (HCAR).
- Removed unnecessary definitions that did not appear in any part of the new Choices for Care regulations.
- Updated "Cash & Counseling" to "Flexible Choices".
- Updated "Enhanced Residential Care" to allow the state to consider additional provider types.
- Updated "Intermediary Services Organization" (ISO) to "Fiscal/Employer Agent" (F/EA).
- Updated "Person-Centered Planning" to align with federal regulations.
- Added new definitions:
    - Authorized Agency
    - DAIL
    - DVHA
    - Extensive Assistance
    - Flexible Funds
    - Imminent Risk
    - Individualized Budget
    - Quality Management

- Service Authorization
- Total Assistance

Section 7.102.3 – General Policies

- Carried over from current regulations.

Section 7.102.4 - Covered Services

- New format with same services as current regulations.
- Increased Moderate Needs Case Management from 12 to 24 hours per calendar year.
- Updated the Flexible Choices/Flexible Funds services cap to accurate reflect change from hours to individualized dollar budgets.

Section 7.102.5 - Eligibility

- Same clinical eligibility language as current rules.
- Same Moderate Needs financial eligibility language as current regulations with some modification for clarity around resources.
- Added reference to LTC Medicaid rules.

Section 7.102.6 - Wait Lists

- High Needs – same as current regulations.
- Moderate Needs – modified wait list language changing from chronological to priority/risk-based.

Section 7.102.7 - Qualified Providers

- Same language from current regulations.
- Added reference to compliance with Universal Provider Standards from current program manual.
- Added reference to compliance with federal HCBS regulations.

Section 7.102.8 - Authorization Requirements

- New language regarding the DVHA Notice of Decision information. (no operational change)
- New language regarding the DAIL service authorization notice. (no operational change)
- Same variance language from current regulations.

Section 7.102.9 - Terminations

- New language to clarify termination reasons and replaces the “Adverse Action” section of current regulations.
- New language regarding provider terminations that aligns with provider-specific licensing/designation rules.

Section 7.102.10 - Non-covered services

- Same language from current regulations about non-duplication of services.
- Same language from current regulations about DS and MH services eligibility.

Section 7.102.11 - Grievance and appeals

- New language to align with federal Medicaid grievance/appeals rules.