VERMONT

State of Vermont *Agency of Human Services*
Department of Disabilities, Aging and Independent Living
Adult Services Division
HC 2 South, 280 State Drive
Waterbury, VT 05671-2020
Phone: 802-241-0294

Choices for Care (CFC) Regulations: Summary of Informal Feedback & State Responses (6/17/19)

1. Adult Day Providers Feedback: The State received comments from three Adult Day providers about an error in the new draft regulations that refers to the adult day services maximum hours as 30 hours per week and it should be 50 hours per week.
   Response: The State agrees this was an error and made the correction to read "50 hours per week".

2. VNAs of Vermont: The Visiting Nurses Association of Vermont offered the following feedback:
   a. Feedback #1: The VNAs recommended that the definition of Personal Care not include Instrumental Activities of Daily Living (IADLs) because that might imply that the home health agencies must do nurse supervision visits for homemaker clients.
      Response: The State will maintain the current definition of "personal care services" for Choices for Care high/highest services which includes IADLs, as the definition of "personal care services" does not affect the nursing supervision requirements outlined in the Home Health Designation Rules. Concerns about nursing supervision are being addressed in the revised/pending Home Health Designation Rules which do not require nursing supervision for "unskilled" homemaker services.
   b. Feedback #2: The VNAs request that the language regarding provider termination of services align with the Home Health Designation rules. They request that both sets of rules account for the fact that a termination due to a "safety risk" to staff can be created by a home environment, not just the behavior of the client or family members.
      Response: The State agrees that the Choices for Care provider termination reasons must align with the Home Health Designation rules. The State recognizes that the home environment may create a safety risk and that it is already captured in the draft language: "The patient, primary caregiver or other person in the home has exhibited behavior such as 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". For example, hoarding is a behavior that may create an unsafe environment that presents a risk to staff. The statement also includes "such as" which means the list is not all inclusive.
   c. Feedback #3: The VNAs would like to see the new regulations change the Moderate Needs clinical eligibility criteria as well as waitlist prioritization.

Response: A change in clinical eligibility criteria requires that the state submit an amendment to the Global Commitment to Health 1115 Waiver (GC) to the Centers for Medicare and Medicaid Services (CMS). Therefore, the State may not change the State regulations without first completing a GC amendment. The State will consider this proposal in time with the next GC amendment or renewal.

d. Feedback #4: Though the VNAs generally support the concept of moving from a chronological waitlist to risk-based prioritization waitlist process for Moderate Needs applicants, they have concern about how those details will work, who will develop the process and how their input will be incorporated. Some specific concerns included how to address waitlists with different case manager organizations in the mix and how the providers with large existing wait lists will make the conversion.
Response: CMS has given the State the green light to modify the Moderate Needs wait list protocol with submission of a new Global Commitment attachment describing the new process. The State recognizes the concerns expressed by the VNAs and will seek stakeholder input prior to formal implementation of a new risk-based wait list protocol.

3. Vermont Legal Aid/Vermont Long-Term Care Ombudsman (VLA/LTCO): VLA/VLTCO provided the following feedback:
   a. Feedback #1: VLA/VLTCO recommends that the "Purpose and Scope" from the old regulations be brought over into the new regulations.
   Response: The State agrees with this recommendation and inserted language about purpose and scope into the new regulations.
   b. Feedback #2: VLA/VLTCO recommends that process language from the old regulations be maintained in the new regulations including "Initial Application Process", "Continued Eligibility Process", "Assessment Process", "Notices" and "Quality Assurance/Quality Improvement".
   Response: The State does not agree with maintaining detailed process language within HCAR. The State believes that detailed process language is best maintained in the program policy/procedures manual. However, the State did agree that some additional quality management language should be maintained in the new regulations.
   c. Feedback #3: VLA/VLTCO believes that the updated definitions of "Assistive Devices/Home Modifications", "Enhanced Residential Care", "Respite", "Resists Care" potentially change the meaning of the definitions and recommends that they remain the same and in the old regulations.
   Response: Though the State did not intend to change the meaning of the definition and does not agree that the meaning has changed with the updated definitions for Assistive Devices/Home Modifications, Respite and Resists Care, the State agrees to use the old language to eliminate the perception of change. However, the definition of Enhanced Residential Care (ERC) has been modified slightly to allow the possibility of future similar provider types to be considered as approved ERC providers.
   d. Feedback #4: VLA/VLTCO pointed out an error in the alphabetizing of the definitions.
   Response: The State agrees and corrected the error.

e. Feedback #5: VLA/VLTCO recommends that "Legal Representative" be changed to align with "Authorized Representative" used in HCAR 8.100.
   Response: The State agrees with this recommendation and made this change.
f. Feedback #6: VLA/VLTCO does not agree with the PASRR definition taken from the old regulations and recommended new language.
   Response #7: The State consulted with the DAIL PASRR experts and received current federal language that will be used to update the definition. This should align with VLA/VLTCO recommendations.
g. Feedback #8: VLA/VLTCO recommends the new regulations add a definition for "Extensive or total assistance".
   Response: The State agrees and has added two new definitions for "Extensive Assistance" and "Total Assistance".
h. Feedback #9: VLA/VLTCO identified that "Cash and Counseling" and "Intermediary Services Organization" were no longer on the list of services and recommended that they should remain in regulation.
   Response: "Cash and Counseling" is now called "Flexible Choices" and is included in the new regulations. "Intermediary Services Organization" is now called "Fiscal Employer Agent" (F/EA) and is included in the new regulations definitions and was added to the services table.
i. Feedback #10: VLA/VLTCO recommends that services maximums be included in the new regulations.
   Response: The State agrees that maximums that refer to hourly services are appropriate to be listed in the new regulations. However, services that are capped by a set dollar amount or budget, will not be referenced in the regulations as they change according to the program budget and individualized plans.
j. Feedback #11: VLA/VLTCO interpreted the new regulations with regards to PASRR screenings, to mean that consumers must have a second PASRR screening done when applying to CFC. Additionally, VLA/VLTCO provided feedback on the language used to describe PASRR screening requirements.
   Response: The intent of this language is not to require a second PASRR screening, but that the State must verify that a PASRR has been done. The State will review the PASRR language and consider modifying for clarity.
k. Feedback #12: VLA/VLTCO recommended that the work "participant" be changed back to "individuals" when referring to reassessments due to clinical ineligibility.
   Response: The word "participant" is used when referring to a person who is already receiving services. This section of the eligibility specifically refers to the criteria used for "participants" who have had a clinical reassessment. Though the State does not agree with VLA/VLTCO's interpretation of the use of the word "participant" in this context, the State is not opposed to using the word "individuals" and will consider that recommendation.

l. Feedback #13: VLA/VLTCO recommends that the new regulations use old language that refers to "DCF Supplemental Security Income (SSI) – related Medicaid regulations applicable to long-term care eligibility".
Response: The State does not agree with this recommendation and is advised to refer to the "Long-Term Care eligibility found in the Health Benefits, Eligibility and Enrollment (HBEE) rules".

m. Feedback #14: VLA/VLTLO recommends that the $10,000 Moderate Needs resource standard be inserted in the regulations.
Response: The State agrees to insert reference to the $10,000 Moderate Needs resource standard. However, the State also intends to correct an error in the old regulations that says people are not eligible if their resources exceeds $10,000. In fact, the $10,000 standards have always been used to calculate an "income adjustment", so people with income above $10,000 may still be found eligible. This is not a change, but a correction in how the old regulations were written. Therefore, the State modified the new regulation language to include reference to the $10,000 and to provide clarity on how that standard is used operationally.

n. Feedback #15: VLA/VLTCO recommends 1) that the new regulations say that DAIL manages the Moderate Needs wait list, 2) that the new regulations include the new wait list prioritization criteria and procedures, and 3) that the State adopt the current High Needs wait list criteria for the Moderate Needs program.
Response: Because the Moderate Needs program is managed based on funding to individual providers, the Moderate Needs wait lists are managed at the provider level, not by DAIL. Additionally, it is the State's intent to work with stakeholders to finalize the new Moderate Needs wait list criteria and process used, which will likely be very close or identical to the High Needs wait list process. Therefore, the State will keep the high-level language in the new regulations "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." Then the State will develop the priority criteria and process with stakeholders and, once that is complete, implement the new procedures in the program policy/procedures manual.

o. Feedback #16: VLA/VLTCO recommends that the new regulations maintain a section about variances and that the DAIL notices will contain language that tells consumers they have the "Right to Request a Variance".
Response: The State already included a section about variances in the "Authorization Requirements" section of the new regulation. The State agrees to maintain the "Right to Request a Variance" language in that same section.

p. Feedback #17: VLA/VLTCO recommends that the "provider termination of services" be struck from the new regulations since some of the CFC providers have those requirements in their provider-specific regulations. If the State chooses to keep the language in the regulations, VLA/VLTCO recommends that the regulations refer to the controlling federal or state regulations for each provider type for consistency and clarity.

Response: The State does not agree with removing the “provider termination of services” section. Instead, it will refer to the provider-specific state regulations when applicable. It is important to note that not all CFC providers have provider-specific federal or state regulations to refer to.