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October 11, 2019

Megan Tierney-Ward, Director and Acting Deputy Commissioner
Department of Disabilities, Aging & Independent Living
280 State Drive, HC 2 South
Waterbury, VT 05671-0270

RE: Draft Choices for Care Regulations in the Medicaid Health Care Administrative Rules (HCAR) format

Megan:

Thank you for the opportunity to provide formal comments concerning the Department's proposed Choices for Care Regulations (in the Medicaid Health Care Administrative Rules - HCAR - format). Our comments are as follows:

A. 7.102.1 Definitions

(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 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.**

(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 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."**

Comment:

1. 7.102.1(r). The terms "Extensive Assistance" and "Total Assistance" are new definitions to the CFC regulations. We believe that the proposed definition for "Extensive Assistance" is too restrictive and does not capture the complexity of evaluating the need for assistance. This definition would constitute a change in policy and make CFC eligibility more restrictive and is therefore not proper as part of this move of the rules into HCAR. The requirement for "weight-bearing support" is too limited and not an appropriate consideration for the need for help with ADLs such as eating and bathing. The scoring for ADL assistance on the current ILA form recognizes that different activities may require different forms of caregiver assistance. For example, under the criteria to score bathing, the criteria for extensive assistance is "physical help in part of bathing activity". Many beneficiaries who need

assistance and qualify for coverage are reluctant to admit they need help and try to maintain their independence as much as possible. The criteria should incorporate the concept that assistance may be required in order to complete the activity safely and within a reasonable period of time. Finally, the proposed definition for “Extensive Assistance” does not align with the Department’s proposed definition of “Total Assistance”.

- We propose that “Extensive Assistance” be edited as follows: “Extensive Assistance” means one of five levels of assistance used when assessing an applicant or participant’s self-performance of Activities of Daily Living. Levels range from “Independent” to “Total” assistance. An applicant or participant is assessed as needing “Extensive Assistance” when “hands on assistance or standby assistance is needed to complete the task safely within a reasonable period of time.”
- We propose that “Total Assistance” be modified as follows: “Total Assistance” means one of five levels of assistance used when assessing an applicant or participant’s self-performance of Activities of Daily Living (ADL). Levels range from “Independent” to “Total” assistance. An applicant or participant is assessed as needing “Total Assistance” when “totally dependent on others to complete the task safely within a reasonable period of time.”
- We find the inclusion of this sentence to be confusing in the definition of “Extensive Assistance” and therefore request that it be removed or revised to clarify the intended meaning: “Total assistance may have been provided three or more times in the last seven days but not in all seven days.”

B. 7.102.6 Wait Lists

7.102.6 (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.**

Comment:

2. 7.102.6(c)(1)(2). The proposed rule lacks any details concerning how the wait list priority system will operate. We recommend that DAIL include, in the proposed CFC regulations, the criteria and procedure to be used to determine eligible applicants place on the Moderate Needs wait list - for consistency, we recommend that DAIL use the “Wait List Procedures” for High Needs participants in the CFC High/Highest Program Operations Manual

(SECTION V.2 “Waiting List Procedures”, p. 74-75) for the Moderate Needs wait list. Also, in the proposed rule, we recommend that DAIL state that it will manage any wait list used for Moderate Needs. It is problematic when the waitlists are managed locally. Local waitlists lack transparency and also unfairly vary the access to services by geography.

C. 7.102.7 Authorization Requirements

7102.7(b) DAIL Service Authorization: All eligible participants (excluding nursing facility) will receive a service authorization notification from the 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.

Comment:

3. 7102.7(b). “Service volume” is not defined in the proposed rule. For consumer understanding and clarity, we recommend that the words “service volume” be replaced with “amount of services”. We also recommend that the sentence beginning with the word “NOTE” and ending with the word “feedback” be removed from the subsection.

D. 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) Financial 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 legal representative;
- (2) The participant has requested that the service(s) be discontinued;
- (3) The participant 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, 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 may 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 the other CFC services are not being successfully utilized, the individual may be terminated from CFC with appeal rights.

Comments:

- 4. 7.102.8. Two technical notes: First, we believe that the current Section 7.102.8 (E) of the proposed rules should be Section 7.102.8(c). Second, we believe that reference to “section 7.102.9” in 7.102.8 is incorrect (section 7.102.9 = “Non-Covered Services” in the proposed rule and does not pertain to notice). The HCAR concerning notice is 8.100.
- 5. 7.102.8(b)(5). We recommend that this subsection be removed in its entirety because it is duplicative and unnecessary; if a “participant no longer requires Choices for Care services”, then the participant must have has been determined to be clinically ineligible for CFC.
- 6. 7.102.8(E)(6). We recommend that this subsection be revised to read “After the participant has vacated an Adult Family Care home following an involuntary move”, because the CFC provider remains responsible for providing CFC services until the participant has permanently vacated the Adult Family Care home.

E. 7.102.9 Non-covered Services

- (a) Choices for Care shall not provide or pay for services to meet the 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.

Comment:

- 7. 7.102.9(b). The Department’s proposed rule is too restrictive. There are individuals with developmental disabilities or mental illness who will age, or develop medical conditions.

These individuals will become eligible for Choices for Care due to their medical condition or infirmity. There are also individuals who are eligible due to dementia, which some people consider to be a mental illness. To deny individuals with mental illness or developmental disability Choices for Care would be an illegal form of disability-based discrimination.

- We proposed that the rule 7.102.9(b) be revised to read as follows: “Individuals who both: (1) need Choices for Care services only due to developmental disability or mental illness; and (2) are determined not to require a nursing home level of services are ineligible for Choices for Care.”

F. 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 the 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.

Comments:

We understand the intent of this section, deleting the separate stand-alone rule on appeals that used to be contained in the CFC rules and cross referencing the HCAR and HBEE rules. But having two separate rules governing appeals is inherently confusing and this rule should be clear in the distinction. The confusion is in part due to the use of the term “eligibility” when describing CFC services, since coverage for CFC is not an eligibility appeal under HBEE but a coverage appeal under HCAR

8. 7.102.10(a)(1). For consumer consistency and clarity, Section 7.102.10(a)(1) should be revised to read “The responsibilities of the Vermont Medicaid Program concerning the grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Choices for Care services is set forth in the Health Care Administrative Rule (HCAR) 8.100. The rule also sets forth requirements for Notices of an Adverse Benefit Determination, continuing services pending appeal and potential beneficiary liability, and responsibilities regarding State fair hearings.”
9. 7.102.10(a)(2). For consumer consistency and clarity, Section 7.102.10(a)(2) should be revised to read “For rules that govern State Medicaid applicant and beneficiary appeals regarding financial, non-financial, and categorical eligibility for community Medicaid and Medicaid for long-term care services and supports refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State Fair Hearing/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for Notices of an Adverse Benefit Determination.

Thank you again the opportunity to comment.

Sincerely,

/S/ Sean Londergan

Sean Londergan, Long-Term Ombudsman Project
Barbara Prine, Disability Project
Michael Benvenuto, Elder Law Project
Bill Dysart, Elder Law Project

TO: Megan Tierney-Ward

FROM: Jill Mazza Olson, Executive Director

DATE: October 11, 2019

RE: Comments on Proposed Choices for Care Rule (GCR 19-059)

Thank you for the opportunity to comment on the proposed Choices for Care Rule.

We have two comments, both of which are related to the moderate needs group:

- 1) As we noted in our comments on the informal draft Choices for Care regulation, we recommend a redesign of the eligibility criteria for the moderate needs program in advance of SFY2021 to ensure that Vermont's limited resources are being targeted at the right Vermonters. Per your email to me on August 27, 2019, we appreciate your willingness to include this change in legislative proposal for the 2022 Global Commitment renewal but hope that you can develop and implement this change more quickly.
- 2) We support the proposal to redesign the moderate needs waiting list prioritization process from chronological to risk-based. As we noted in our comments on the informal draft Choices for Care regulation, we request that you include us in the process of developing a new methodology and planning for a transition because it may be overly burdensome to apply retroactively to large waiting lists. We appreciate the Department's stated willingness to meet these requests, but felt it was important to include this in our formal comments since the process is not yet in place.

Schurr, Stuart

From: Laura Pelosi <laura@mmrvt.com>
Sent: Thursday, October 3, 2019 6:10 PM
To: Tierney-Ward, Megan
Cc: Schurr, Stuart; Sherry Callahan
Subject: Comments Draft Choices for Care Regulations

Good afternoon Megan,

Please consider these comments on behalf of the Vermont Health Care Association (VHCA):

7.102.2(p) as drafted would expand the definition of Enhanced Residential Care to include services provided to an individual residing in a licensed Residential Care Home, Assisted Living Residence or similar state-licensed facility that has been approved by DAIL to provide these services. VHCA understands from prior responses provided by the State that the intention is to expand the type of providers in the future that may provide these services. VHCA is concerned about the lack of current information regarding the scope of this change. The ERC system is highly fragile. Expanding an already under-funded system to incorporate additional types of providers may further strain and weaken the sustainability of the ERC system. In addition, the Division of Licensing and Protection is in the process of preparing draft regulations for Residential Care Homes and Assisted Living Residences. The potential for more stringent regulatory requirements, accompanied by limited resources, also has the potential to strain the system. VHCA recommends that the current system be adequately supported, and that the State identify more concretely the types of providers and the regulatory framework it envisions before expanding the definition.

7.102.2(y) modifies the definition of "Home and Community Based Services" to exclude licensed facilities. The current rule excludes nursing homes only. VHCA is concerned that this change presumes that licensed residential care homes and assisted living residences are not HCBS settings. VHCA is concerned about the impact on the residents who choose to receive their services in these settings. While the federal HCBS rules place heightened scrutiny on various types settings, VHCA believes this definition is too stringent and limiting, and does not allow for a determination that such a setting is a HCBS setting.

Thank you for your consideration of these concerns.