State of Vermont
Agency of Human Services
Department of Disabilities, Aging and Independent Living

TO: Legislative Committee on Administrative Rules (LCAR)

FROM: Stuart G. Schurr, Esq., General Counsel SGS
Department of Disabilities, Aging & Independent Living (DAIL)

DATE: January 20, 2020

SUBJECT: 19P-054; Final Proposed Rule; *Choices for Care*

The Agency of Human Services (AHS) and DAIL propose numerous amendments to the existing *Choices for Care* Regulations.

A. Background

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.

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.

Specific Changes

The following chart reflects all changes made to the proposed rule since its filing with the Secretary of State.

Regulatory Provision (as listed in the proposed rule)	**Description of Change**
7.102.2(p)	The State deleted "similar state-licensed facility that has been approved by DAIL to provide these services" and replace with "Home for the Terminally Ill"

Regulatory Provision (as listed in the proposed rule)	Description of Change
7.102.2(r), (ww)	The State revised these definitions for clarity to read as follows: (r) "Extensive Assistance" means one of five levels of assistance used when assessing an applicant or participant's self-performance of Activities of Daily Living. Levels range from "Independent" to "Total" assistance. An applicant or participant is assessed as needing "Extensive Assistance" when hands on assistance or standby assistance is needed to complete the task safely within a reasonable period of time and when the assistance has been provided three or more times in the last seven days. (ww) "Total Assistance" means one of five levels of assistance used when assessing an applicant or participant's self-performance of Activities of Daily Living (ADL). Levels range from "Independent" to "Total" assistance. An applicant or participant is assessed as needing "Total Assistance" when totally dependent on others to complete the task safely within a reasonable period of time.
7.102.2(y)	Inserted, "those provided at" licensed facilities.
7.102.4	Added (agency directed) next to personal care, companion/respite in the service table.
7102.7(b) Authorization Requirements	The words "service volume" have been replaced with "amount of services". Also, the sentence beginning with the word "NOTE" and ending with the word "feedback" has been removed from the subsection.
7102.7	This section has been re-numbered to 7.102.8, resulting in the re-numbering of all subsequent sections, and (D) Variances is changed to (c).
7.102.8. Terminations	(E) has been changed to (c). Further this section has been re-numbered as 7.102.9, resulting in the re-numbering of all subsequent sections. The reference to section 7.102.9 is incorrect and has been modified to reference 7.102.11, the re-numbered section on "Appeals, Grievances and Fair Hearings" (b)(5) has been modified to read as follows: "The participant is not utilizing any of their CFC services for more than 90 consecutive calendar days."

Regulatory Provision (as listed in the proposed rule)	Description of Change
	The following sentence has been eliminated: "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." The following has been deleted: " (6) Involuntary move from an Adult Family Care home (AFC)" as a provider termination reason.
7.102.8 Terminations	The current (E)(5) (re-lettered to (c)(5)) has been revised to eliminate the reference to "imminent risk" and to align with language in new home health designation rules. See Section 16.4(c)(iii). The revised subsection reads as follows: "The participant, primary caregiver or other person in the home has exhibited behavior, including, but not limited to, physical abuse, sexual harassment, verbal threats or abuse or threatening behavior that poses a safety risk to agency staff."
7.102.9 Non-Covered Services	This section has been re-numbered to 7.102.10. The word "primary" has been changed to "only."
7.102.9 Non-Covered Services	The title of this section has been changed to "Limitations".
7.102.10	This section has been re-numbered to 7.102.11 and modified to reads as follows. 7.102.11(a)(1). The responsibilities of the Vermont Medicaid Program concerning the grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Choices for Care services are set forth in the Health Care Administrative Rule (HCAR) 8.100. The rule also sets forth requirements for Notices of an Adverse Benefit Determination, continuing services pending appeal and potential beneficiary liability, and responsibilities regarding State fair hearings. 7.102.11(a)(2). For rules that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical and clinical eligibility for Choices for Care,

Regulatory Provision (as listed in the proposed rule)	Description of Change
	refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action. (c) has been deleted, as its content is addressed in (a)(1) above)
7.102.11 Quality Assurance and Improvement	This section has been re-numbered to "7.102.12."

Rulemaking Process – Public Input

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 the proposed rule.

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

When the rule was filed with the Office of the Secretary of State, AHS provided 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.

Following the public hearing, which was held on October 4, 2019, DAIL received public comments from several of the above stakeholders. DAIL has considered the comments received and has incorporated suggested changes, as appropriate.

Below is a summary of the comments received and the DAIL's response to those comments.

B. Public Comments and DAIL's Responses

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Section	**Comments**	**Responses**
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.	The State agrees to delete "similar state-licensed facility that has been approved by DAIL to provide these services" and replace with "Home for the Terminally Ill"
7.102.2(r), (ww)	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	The State agrees to revise these definitions for clarity to read as follows: (r) "Extensive Assistance" means one of five levels of assistance used when assessing an applicant or participant's self-performance of Activities of Daily Living. Levels range from "Independent" to "Total" assistance. An applicant or participant is assessed as needing "Extensive Assistance" when hands on assistance or standby assistance is needed to complete the task safely within a reasonable period of

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	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."	time and when the assistance has been provided three or more times in the last 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 is assessed as needing "Total Assistance" when totally dependent on others to complete the task safely within a reasonable period of time.
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.	Yes, the new regulations modified the definition of "Home and Community-Based Services" (HCBS). Since the implementation of the new HCBS regulations in 2014, the State clarified with CMS that Vermont's ERC/ACCS services are designated as "PNMI," or Private Non-Medical Institution. These rules are intended to align the HCBS terminology with the CMS HCBS terminology and will

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		have no impact on the delivery of services to Vermonters in ERC or ACCS.
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 placed 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.	The state recommends no changes to the language for the following reasons: • The new MNG priority wait list process will not be operationalized until DAIL has established the process with stakeholders. • DAIL's lack of access to the daily funding availability status of the provider-based funding caps makes DAIL management of MNG wait list impracticable. DAIL is open to suggestions with regard to transparency of local Moderate Needs wait lists to ensure equitable access.
7102.7(b) Authorization Requirements	"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.	The State agrees to make these changes.
7.102.8. Terminations	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	The State agrees that (E) should be (c). Further this section has been re-numbered as 7.102.9, resulting in the re-numbering of all subsequent sections. The State also agrees that the reference to section 7.102.9 is incorrect. This will be modified to reference 7.102.11, the re-numbered section on "Appeals,

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	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.	Grievances and Fair Hearings" The proposed language in (b)(5), which reads, "The participant no longer requires Choices for Care services to remain in setting of choice," is intended to address the non-use of services. The State recommends modifying (b)(5) to read as follows: "The participant is not utilizing any of their CFC services for more than 90 consecutive calendar days." Additionally, the state proposes to eliminate the following sentence: "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." The state proposes to delete the following: " (6) Involuntary move from an Adult Family Care home (AFC)" as a provider termination reason. The Adult Family Care Home provider is not terminating "services" when a person moves from the home. Management of Home Provider shared living agreements and notice of moving is managed in the Choices for Care program manual. In the event of an involuntary move from and AFC home, the Authorized Agency remains responsible

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		for helping the participant find a new AFC home provider or other CFC services.
7.102.9 Non-Covered Services	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."	This section has been re-numbered to 7.102.10. The State notes that the proposed language aligns with the language in the current rule and is, therefore, no more restrictive. Nonetheless, to reflect its intent, the State agrees to change the word "primary" to "only."
7.102.10	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. 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	This section has been re-numbered to 7.102.11. The State agrees with this proposal to the extent that it provides greater clarity for applicants and beneficiaries. The State disagrees, however, that an action concerning one's eligibility for CFC is covered by HCAR 8.100. HCAR 8.100 et seq., which aligns with the managed care appeal rules set forth in 42 CFR Part 438, Subpart F, applies exclusively to coverage for Medicaid benefits and services. On the other hand, the HBEE rule, which aligns with 42 CFR Part 431, applies to decisions

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	beneficiary liability, and responsibilities regarding State fair hearings." 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.	concerning one's financial, non-financial, categorical or clinical eligibility to receive CFC services. The State proposes to adopt a modified version of this recommendation, which reads as follows: 7.102.11(a)(1). The responsibilities of the Vermont Medicaid Program concerning the grievance and internal appeal system for Medicaid beneficiaries seeking coverage for Choices for Care services are set forth in the Health Care Administrative Rule (HCAR) 8.100. The rule also sets forth requirements for Notices of an Adverse Benefit Determination, continuing services pending appeal and potential beneficiary liability, and responsibilities regarding State fair hearings. 7.102.11(a)(2). For rules that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, categorical and clinical eligibility for Choices for Care, refer to Health Benefit Eligibility and Enrollment Rules (HBEE) Part 8 (State fair hearings/expedited eligibility appeals). HBEE Part 8 also sets forth the requirements for maintaining benefits/eligibility pending a State fair hearing. HBEE Part 7 (Section 68.00) contains the requirements for notices of an adverse action.

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		The State proposes to strike (c), as its content is addressed in (a)(1) above)
Submitted late (Due 10/11/19: received 10/14/19)	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.	This comment was received after the public comment period had closed. Nonetheless, the State has reviewed and noted the comment.
Submitted late (Due 10/11/19: received 10/14/19)	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.	This comment was received after the public comment period had closed. Nonetheless, the State has reviewed and noted the comment.