

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

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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 and 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
Resists Care
Behavioral Symptoms

Verbally Aggressive Behavior
Physically Aggressive Behavior

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
2 nd or 3 rd 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
Medication Injections
Parenteral Feedings
Tube Feedings

Suctioning
End Stage Disease
Severe Pain Management

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 or 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 or other liquid assets, excluding primary residence or one car, 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 the Department or 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: All applicants will be provided with information about the financial eligibility requirements for Choices for Care at the time of the initial application. The Department shall provide the DCF Medicaid long-term care eligibility form to any applicant upon request of the applicant or legal representative. Applicants requiring admission or already admitted to a nursing facility or who clearly meet the Highest Needs group clinical eligibility criteria shall be provided the DCF Medicaid long-term care eligibility form at the same time as the application and shall be encouraged to submit the form as soon as possible.

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 5.5 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 5.5 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.

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.~~

A. Department decisions are considered preliminary decisions subject to appeal or reconsideration. If no request for a Commissioner's hearing is filed or request for reconsideration made within the timeframes set out in these rules, the original decision is

considered the final decision. If an appeal is filed, the decision rendered as a result of the appeal is the final decision. These rules should not be construed to preclude reconsideration of a decision by the staff member who made the original decision.

B. Reconsideration is a process by which an applicant or participant, or his or her legal representative, may request a review of an MCO decision by the individual or entity that made the original decision.

1. A request for reconsideration may be made orally or in writing by the applicant or participant or his or her legal representative.

2. A request may be accompanied by any additional information that supplements or clarifies material that was previously submitted and is likely to materially affect the decision.

3. A request for reconsideration can be made up to 30 days after the date of the notice of decision.

4. A decision pursuant to such reconsideration shall be rendered within 15 days of receipt of the request.

5. A request for reconsideration does not suspend the 90 day time frame for filing of appeals.

6. A request for reconsideration is not considered an appeal.

BC. 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 request 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~~ 90 days of the date of the notice of decision. The date of the appeal, if mailed, is the postmark date.

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 05671-1601
802-241-2401

4. Department staff shall assist applicants or participants to initiate the filing of an appeal. Applicants and participants shall not be subject to retribution or retaliation for appealing a Department decision.

5. Written acknowledgement of the request for a Commissioner's hearing appeal shall be mailed within five calendar days of receipt. If the issue is resolved within the five-day time frame, a single decision notice may be sent; a separate receipt acknowledgement is not required.

6. Participants or their legal representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the Department shall acknowledge the withdrawal in writing within five calendar days.

7. The participant or his or her legal representative, if applicable, has the right to participate in person, by telephone or in writing in the Commissioner's hearing. Participants or their legal representative may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They also will be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

8. The Commissioner shall notify the participant as soon as the Commissioner's hearing is scheduled. Hearings will be held during normal business hours and, if necessary, will be rescheduled to accommodate individuals wishing to participate. If a scheduling or rescheduling results in exceeding the 45 day limit, an automatic 14 day time extension is effective. If a meeting cannot be scheduled within the 45 day time limit and 14 day extension, a decision will be rendered by the Commissioner without a meeting with the participant or his or her legal representative.

49. The Commissioner shall send written notice of the decision, with appeal rights, to the applicant or participant within forty-five (45) days of the completion of the hearing. The 45 day period begins with the receipt of the appeal. If an appeal cannot be resolved within 45 days, the time frame may be extended up to an additional 14 days by request of the participant, or by the Commissioner if the extension is in the best interest of the participant. If the extension is at the request of the Commissioner, the Commissioner must give the participant written notice of the reason for the delay. The maximum total time period for the resolution of an appeal, including any extension requested either by the participant or the Commissioner, is 59 days.

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. If requested by the beneficiary, services must be continued during an appeal under the following circumstances:

a. The appeal was filed in a timely manner, meaning before the effective date of the proposed action;

b. The participant has paid any required premiums in full;

c. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan;

d. Any applicable annual plan of care has not expired at the time the appeal is filed; and

e. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.

45. 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 affecting some or all beneficiaries, or when the decision does not require advance notice.

6. Participants may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively, if applicable.

7. The Department is allowed to recover the value of any benefits paid during the appeal period when the participant withdraws the appeal before the relevant Commissioner's hearing or fair hearing decision is made, or the reason for the appeal is an issue of law or policy and the Department's position is affirmed by the Commissioner or fair hearing decision. An issue of law or policy means that the person is questioning the legality of a law or rule rather than the facts used or the Commissioner's judgment in applying the rules to make the decision being appealed.

8. Where properly requested, a service must be continued until any one of the following occurs:

a. The participant withdraws the appeal;

b. Any limits on the cost, scope or level of service have been reached;

c. The Commissioner issues a decision adverse to the applicant or participant, and the applicant or participant does not request a fair hearing within the applicable time frame;

d. A fair hearing is conducted and the Human Services Board issues a decision adverse to the applicant or participant;

e. Any applicable annual treatment plan has expired; or

f. The original service period ordered by an authorized provider has expired.

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.

GF. 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 request may request a fair hearing with the Human Services Board.

2. An applicant or participant must exhaust the Department's internal appeal process, which is a Commissioner's review hearing, before requesting a fair hearing.

23. The request for a fair hearing must be made within ~~ninety (90)~~ thirty (30) days of the date of the notice of decision by receiving the written notice of determination or the written notice of the decision of the Commissioner.

34. A request for a fair hearing shall be made to:

Human Services Board
120 State Street
Montpelier, VT 05620-4301
802-828-2536

FG. 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.

H. Liability for Cost of Services

1. A participant may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

2. The Department may recover from the participant the value of any continued benefits paid during the appeal period following a final disposition of the matter in favor of the Department. Participant liability will occur only if an appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the Commissioner also determines that the participant should be held liable for service costs.

3. If the provider notifies the participant that a service may not be covered by Medicaid, the participant can agree to assume financial responsibility for the service. If the provider fails to inform the participant that a service may not be covered by Medicaid, the participant is not liable for payment. Benefits will be paid retroactively for participants who assume financial responsibility for a service and who are successful on such service coverage appeal.

I. Grievance is an expression of dissatisfaction about any matter that is not an action, such as the quality of a service provided or aspects of interpersonal relationships.

1. A grievance may be expressed orally or in writing. Dissatisfaction expressed orally is an informal grievance. Dissatisfaction expressed in writing is considered a formal grievance. Informal grievances that are not addressed within 72 hours become formal grievances. A

grievance must include a clear statement by the applicant that a response is requested from the Department.

2. A participant or his or her legal representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Formal grievances will be documented on a standard Grievance/Appeal Form. Staff members will assist a participant if the participant or his or her legal representative requests such assistance.

3. The Department shall acknowledge formal grievances in writing and shall mail the acknowledgement within five calendar days of receipt, or in cases of informal grievances not addressed after 72 hours, within five calendar days after it becomes a formal grievance. If the Department decides the issue within the five day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in these cases.

4. All grievances shall be addressed within 60 calendar days of receipt. For formal grievances, the decision-maker must provide the participant with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making a decision, and the disposition.

a. If a grievance cannot be addressed within 60 days, the time frame may be extended up to an additional 30 days upon request of the participant. The participant may also extend the time frame for disposition on its own initiative if the extension would be in the participant's best interest. If the Commissioner decides to extend the time frame, he shall provide the participant written notice of the reason for the delay.

b. The Commissioner shall notify the participant in writing of the disposition of the grievance, which is not subject to be appealed to the Human Services Board.

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.