

ATTENDANT SERVICES PROGRAM Regulations

**Medicaid: Participant-Directed Attendant Care Services
General Fund: Participant-Directed Attendant Care Services
Personal Services
Group-Directed Attendant Care Services**

February 28, 2009

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

This material is available upon request in alternative formats

Table of Contents

<u>SECTION</u>	<u>PAGE</u>
Policy	1.
101 Statutory Basis	1.
102 Purpose.....	1.
103 Definitions.....	1.
104 Applications	3.
105 Eligibility Criteria	4.
a. General.....	4.
b. Personal Services	4.
c. Participant Directed Attendant Services	4.
d. Medicaid Participant Directed Attendant Services	4.
e. Group Directed Attendant Services	4.
106 Eligibility Determination	5.
a. Committee System	5.
b. Committee Membership.....	5.
c. Committee Responsibilities	5.
107 Services	5.
108 Extent of Services	5.
a. Maximum.....	5.
b. Flexibility.....	5.
c. Multiple Programs	6.
d. Duration	6.
e. Insufficient Program General Funds	6.
f. Other Available Sources of Payment	6.
g. Absences from the State.....	6.
h. Special Circumstances	6.
109 Participants.....	6.
a. Oversight of Personal Assistants	6.
b. Payroll Reports.....	7.
c. Department Requests	7.
d. Compliance with Laws.....	7.
e. Notice of Changes.....	7.
f. Program Agreement	7.
110 Personal Assistants.....	8.
a. Who.....	8.
b. Legal Obligations	8.
c. Training.....	8.
d. Payment Schedule	8.
e. Notice of Benefits	8.
f. Special Circumstances	8.
111 Confidentiality	8
112 Appeals	9.
a.	9.
b. Commissioner’s Review	9.
c. Expedited Appeal Requests	10.

d.	Financial Eligibility Determinations	11.
e.	Notices, Continuation of Services, Participant Liability for Services Costs	11.
f.	Participant Liability for Cost of Services	12.
g.	Appeals Regarding Proposed Services	12.
h.	Fair Hearing	12.
i.	Grievances.....	12.
113	Program Evaluation	13.
a.	Annual Survey.....	13.
b.	Annual Meetings.....	13.
114	General Fund Policy.....	13.

**Department of Disabilities, Aging and Independent Living
Disability and Aging Services**

POLICY

It is the policy of the Department to foster the development of services which assist older persons and persons with disabilities to live as independently and to retain as much personal control over the manner in which its programs affect them as their personal circumstances permit. Toward these ends, the programs of this division are administered in ways which:

- a. Focus first and foremost on the needs, interests, and abilities of their participants as individuals;
- b. Enable participants to exercise as much control as they wish and as they can over the direction and provision of their services; and
- c. Encourage decisions about their operation to be made as much as is feasible at the local community level.

It is the policy of the Department to use Medicaid funding to support attendant services when the applicant or participant is eligible for Medicaid-funded attendant services, and to use available General Fund monies to support attendant services only when this is not feasible. To the extent possible, the Attendant Services Program will be managed so as to assure that monies are available for General Fund services.

ATTENDANT SERVICES PROGRAM REGULATIONS

101. STATUTORY BASIS

These regulations are promulgated pursuant to 33 V.S.A. §6321(d), relating to the provision of attendant services.

102. PURPOSE

While attendant services may not be sufficient, by themselves, to enable persons with disabilities to achieve their maximum potential in their communities, they are a necessary component of any service system with that goal. It is the purpose of the Attendant Services Program to foster independence by paying, within the limits of available funds, for attendant services in Vermont for eligible adult Vermonters residing in settings where such services are not otherwise available. It is also the purpose of the Attendant Services Program to enable its participants to exercise as much control as they wish and as they can over the direction and provision of their attendant services.

103. DEFINITIONS

As used in these regulations:

- (a) "Action" means an occurrence of one or more of the following by the Department for which an internal appeal may be requested:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

Note: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

- (b) “Activities of daily living” means the assistance activities required for eligibility for the Attendant Services Program, which include dressing and undressing; bathing, showering, and grooming; toileting; transferring; bed mobility; range of motion exercises; positioning; eating and ambulation and mobility in and around the home.
- (c) “Adult” means an individual at least 18 years old.
- (d) “Appeal” means a request for an internal review of an action by the Department.
- (e) “Applicant” means an individual who has submitted to the Department a completed application for attendant services.
- (f) “Attendant services” means assistance with personal care (including dressing, bathing, shaving, and grooming), eating, meal preparation, and ambulation. 33 V.S.A. §6321(d).
- (g) “Department” means the Department of Disabilities, Aging and Independent Living.
- (h) “Expedited Appeal” means an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.
- (i) “Grievance” means an expression of dissatisfaction about any matter that is not an action, such as the quality of care or service provided or aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the participant’s rights. If a grievance is not acted upon within the timeframes specified in rule, the participant may ask for an appeal under the definition of an action as being “failure to act in a timely manner when required by state rule.” If a grievance is composed of a clear report of alleged physical harm or potential harm, the Department will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services.)
- (j) “Managed Care Organization” (“MCO”) means:
1. the Office of Vermont Health Access (“OVHA”);
 2. any State department with which OVHA has an Intergovernmental Agreement under the Global Commitment 1115(a) waiver that results in that department administering or providing services under the Global Commitment waiver (i.e. Department for Children and Families, Department of Disabilities, Aging and Independent Living, Department of Health, Division of Mental Health);
 3. a DA/SSA; and
 4. any contractor performing service authorizations or prior authorizations on behalf of the Department.
- (k) “Participant” means an individual for whom attendant services have been authorized in accordance with these regulations.

(l) “Participant-directed” means services that are managed and controlled by an individual who is capable of assuming responsibility for, among other tasks, recruiting, hiring, training, scheduling, supervising and terminating an employee.

(m) “Personal assistant” means a person who, for compensation, provides attendant services.

(n) “Person with disabilities” means an individual who has a functional physical limitation by virtue of physical or psychological conditions requiring hands-on assistance with activities of daily living.

(o) “Primary services” means services that assist an individual with personal maintenance and mobility, including the following:

1. Dressing and undressing;
2. Bathing;
3. Grooming;
4. Toileting;
5. Assistance with medication and/or health maintenance equipment;
6. Assistance with adaptive equipment;
7. Transferring;
8. Ambulation and mobility in and around the home, bed mobility, range of motion exercises, and positioning;
9. Eating; and
10. Preparing meals.

(p) “Request for Reconsideration” means a process by which an applicant, participant or designee may request a review of a Department decision by the individual or entity that made the original decision. A request for reconsideration is not considered an appeal.

(q) “Secondary services” means services which assist an individual with other activities, including the following:

1. Housekeeping chores, such as cleaning and laundering;
2. Shopping;
3. Household maintenance, such as snow removal, hauling firewood, changing storm windows and screens, and yard work;
4. Transportation;
5. Infant and child related tasks such as bathing, dressing and feeding, to the extent that the child cannot perform these tasks (this service can be reimbursed under general fund services but cannot be reimbursed under Medicaid PDAC);
6. Care of support animals such as seeing-eye dogs and hearing ear dogs;
7. Guiding a participant who is blind or visually impaired from place to place;
8. General care and cleaning of adaptive tools and equipment; and
9. Managing personal finances and mail, including paying bills and writing checks.

104. APPLICATIONS

Application forms for the Attendant Services Program shall be available at any office of the Department and shall be made available to prospective applicants at generally accepted sources of referral for attendant services, such as independent living centers, area agencies on aging, rehabilitation centers, nursing homes, and hospital discharge units. The application shall be completed by the applicant or his or her designee prior to being submitted to the Department.

105. ELIGIBILITY CRITERIA

(a) General. To be eligible for any services, a person must meet specific eligibility requirements for a category of services (listed in subsections b, c, d and e below) and be an adult resident of Vermont in need of attendant services to avoid dependency.

(b) Personal Services. To be eligible for services under the Personal Services, an individual shall:

1. Have a disability;
2. Be eligible to receive Medicaid; and either
3. Need attendant services for at least one activity of daily living or meal preparation; *or*
4. Be an active participant in the Attendant Services Program, have a continued need for attendant services, and be ineligible for other sources of attendant services.

(c) Participant Directed Attendant Services. To be eligible for Participant Directed Attendant Services, an individual shall:

1. Have a permanent and severe disability;
2. Need attendant services for at least two activities of daily living; and
3. Be capable of directing his or her attendant care services.

(d) Medicaid Participant Directed Attendant Services. To be eligible for Medicaid Participant Directed Attendant Services, an individual shall:

1. Have a permanent and severe disability;
2. Need attendant services for at least two activities of daily living;
3. Be capable of directing his or her attendant care services;
4. Be eligible for Medicaid; and
5. Be able and willing to employ attendants other than his or her spouse or civil union partner.

(e) Group Directed Attendant Services. To be eligible for Group Directed Attendant Services, an individual shall:

1. Have a permanent and severe disability;
2. Need attendant services for at least two activities of daily living;
3. Need no fewer than four hours of attendant services daily;
4. Live as part of a group of eligible individuals in a group living situation, approved by the Department; and
5. Be capable of directing his or her attendant care services.

To the extent that funds are available for this purpose, the Department will support the development of Group Directed Attendant Services.

106. ELIGIBILITY DETERMINATION

(a) **Committee system.** Committees appointed by the Department shall determine the eligibility of applicants. The Department shall develop, where feasible, regional eligibility committees to determine such eligibility in the region where an applicant resides. The Department shall also maintain a committee at the state level, which shall oversee the work of the regional committees to assure objective and consistent consideration of applicants across the state, and which shall serve as the eligibility committee for regions without one of their own. The Department shall adopt eligibility committee determinations unless they are inconsistent with written Department guidelines. The Department shall reject, amend and/or revise determinations that are found to be inconsistent with Department guidelines.

(b) **Committee membership.** Each eligibility committee shall consist of at least three persons, and a quorum of each committee shall consist of at least three persons. A majority of the members of each committee and of any quorum shall be Attendant Services Program participants, and at least one member of each committee shall be a member of the staff of the Department. The Department shall establish written guidelines for selection of participant-members of eligibility committees. Such guidelines shall assure that the best interests of applicants and participants are served.

(c) **Committee responsibilities.** The eligibility committee shall determine consistently with Department guidelines:

1. If an applicant is eligible for attendant services;
2. If so, the extent of the applicant's need for attendant services;
3. How much service should be authorized, in accordance with section 108, relating to extent of services; and
4. Each participant's continuing eligibility and extent of need for attendant services as requested by the Department, but in no event less than annually.

107. SERVICES

Program funds are available to pay for assistance with "Primary services". Program funds are also available to pay for assistance with "Secondary services" if they occupy no more than half the time for which services are paid. Assistance with secondary services shall be limited to a maximum of 50% of the total award.

108. EXTENT OF SERVICES

(a) **Maximum.** The Department may authorize payment for up to 13 hours of attendant services per day every day of the year, to the extent they are determined by the eligibility committee to be needed by the applicant or participant.

(b) **Flexibility.** The eligibility committee shall permit varying amounts of daily service in accordance with the individual needs of the applicant or participant. In addition, a participant may, within each two-week period, adapt to his or her variable needs the total number of hours for which attendant services are authorized.

(c) Multiple programs. A person may apply to or be enrolled in more than one attendant services program covered by these regulations at any one time. A person may receive services from one attendant services program and remain on a waiting list for another attendant services program.

(d) Duration. Subject to the availability of funding, individual participants may continue to receive attendant services as long as they remain eligible.

(e) Insufficient program general funds. If program general funds are insufficient to meet the needs of all eligible applicants for general fund services, the Department shall maintain applicant waiting lists for each general fund service, by date of submission of completed application, and shall determine eligibility and admit eligible applicants to the program, as general funds become available, in the order in which they apply.

(f) Other available sources of payment. An individual who is eligible for Medicaid-funded personal care or attendant care services shall not be eligible to receive services from the following options paid for by the General Fund: Personal Services, Participant-Directed Attendant Services or Group-Directed Attendant Services. As a condition of receiving services under General Fund Personal Services, Participant-Directed Attendant Services or Group-Directed Attendant Services, an individual shall be required by the Department to apply and be found ineligible for services from other Medicaid-funded personal care or attendant care services programs.

1. If a participant employs his or her spouse, and the spouse lives in the household with the participant, and if participation in the Choices for Care Medicaid Waiver Program would mean that the spouse could no longer be paid to perform IADL services for the participant, the participant may continue to participate in the Attendant Services Program.

(g) Absences from the State. Program funds may be used to pay for attendant services for participants who are absent from Vermont for a period not to exceed six weeks. When an absence from Vermont exceeds six weeks, the Department, thereafter, will consider the specific circumstances of the participant in deciding whether to continue such payment.

(h) Special circumstances. A temporary increase in attendant services, depending on available funds, may be available to a participant when the personal assistant cannot perform his or her duties due to illness or personal circumstances and there is not enough time to make other arrangements for the participant.

109. PARTICIPANTS

(a) Oversight of personal assistants. Participants are encouraged to exercise as much control as they wish and as they can over the direction and provision of their attendant services. The Department will act as or designate another entity as the payroll agent for the program. A participant in Participant Directed Attendant Services or Medicaid Participant Directed Attendant Services shall accept personal responsibility for all of the requirements listed below regarding his or her personal assistant. A participant in Personal Services shall accept personal responsibility for or designate another person as an agent to carry out some or all of the

requirements listed below regarding the personal assistant. If the participant has a guardian, the Department shall require the guardian to accept personal responsibility for or designate another person as an agent to carry out some or all of the requirements listed below regarding the personal assistant. If the Department has reason to believe the participant or the person designated to carry out these requirements is unsuitable to do so, it may require someone else to be designated to do so. With respect to Group Directed Services, the group itself shall carry out these requirements in accordance with its own governing rules:

1. Hiring, training, supervision, and firing of personal assistants;
2. Establishing work schedules;
3. Approving personal assistant time reports and submitting them to the Department or the designated payroll agent;
4. Assuring that all benefits to which the personal assistant is entitled are provided;
5. Keeping payroll records; and
6. Maintaining any other records as determined by the participant or as required by the Department.

(b) Payroll reports. Participants shall submit payroll reports as required by the established payroll procedures and schedule.

(c) Department requests. Participants shall provide all information requested by the Department, including surveys of all program participants conducted for planning and evaluation purposes.

(d) Compliance with laws. Participants shall comply with all federal and state laws affecting employment relationships, including but not limited to such matters as hiring, benefits, conditions of work, and firing.

(e) Notice of changes. Participants or their designees shall notify the Department as soon as possible about any of the following matters:

1. Changes in name, address, telephone number, personal assistant, amount of attendant services needed, or guardianship, agent, or designee, if any;
2. Plans to leave the State or actual absences from the State in excess of six weeks;
3. Hospitalization;
4. Stays in residences (such as residential care homes or nursing homes) where attendant services are available to residents;
5. Changes in Medicaid eligibility;
6. Changes in the type or amount of assistance services received through any other source or program (such as a Medicaid Waiver, a home health agency service, or a Homemaker service); and/or
7. Changes in need for attendant services (including changes in disability, medical condition, or living situation which substantially affect the need for attendant services).

(f) Program agreement. Participants shall indicate their agreement with the type and amount of attendant services authorized and the conditions of their participation in the program by signing an annual Attendant Services Program Agreement.

110. PERSONAL ASSISTANTS

(a) Who. A participant may choose his or her personal assistant. More than one person may provide attendant services to the same participant, within the amount of services authorized by the Department. Restrictions:

1. A spouse may not be reimbursed for attendant care through Medicaid services.
2. An attendant who has a substantiated history of abuse, neglect, or exploitation may not be reimbursed for attendant care services.

(b) Legal obligations. The participant, guardian or agent shall assure that all personal assistants are employed in compliance with all applicable State and Federal laws affecting employment relationships.

(c) Training. Generally, participants are in the best position to know the nature of the attendant services they want and need. As a result, for purposes of this program, personal assistant training is normally the sole responsibility of the participant. The Department is available to provide technical assistance as requested, within the limits of available resources.

(d) Payment schedule. The Department or the designated payroll agent shall establish a standard payment schedule for all personal assistants, and shall distribute this schedule to all participants.

(e) Notice of benefits. The Department shall provide printed information to participants and personal assistants regarding benefits available to personal assistants through this program.

(f) Special circumstances.

1. Change in personal assistant. When there is a change in personal assistant for a participant, the Department will pay for the incoming personal assistant as well as the outgoing personal assistant for up to three days, to assure there is no break in services. In order to obtain such payment, the participant shall provide to the Department prior written evidence that the personal assistant has either resigned or been fired and a notice specifying the day or days involved.
2. Participant hospitalization. To ensure continued availability of attendants for participants who will return home, the Department will use available General Funds to continue payment of a personal assistant for a period of up to 30 days during which a participant is hospitalized. The Department, thereafter, will consider the specific circumstances of the participant in deciding whether to continue such payment.

111. CONFIDENTIALITY

To the extent permitted by law, the Department and eligibility committee shall protect the confidentiality of all program records relating to individual applicants and participants and shall ensure the identity of participants is not disclosed to the public except with the written consent of the applicant

or participant, except in the context of an administrative or judicial proceeding involving the applicant or participant, or upon order of a court. Eligibility committee members who are not on the staff of the Department shall adhere to the same policies and standards of confidentiality as staff members of the Department.

112. APPEALS

The Attendant Services Programs are part of “Global Commitment to Health,” which is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Office of Vermont Health Access, as a Managed Care Organization (“MCO”) under the Global Commitment 1115(a) waiver, is required under 42 C.F.R. Part 438, Subpart F, to have an internal grievance and appeal process for resolving service disagreements between participants and Department employees and representatives of the Department.

An applicant or participant may request an internal review by the Commissioner and a fair hearing before the Human Services Board. An applicant or participant may use the internal Commissioner’s review while a fair hearing is pending or before a fair hearing is requested, except when a services is denied, reduced or eliminated as mandated by federal or state law or rule, in which case the applicant or participant cannot use the internal review by the Commissioner and must appeal the decision by requesting a fair hearing before the Human Services Board.

(a) The Department encourages any applicant or participant who disagrees with a decision of the eligibility committee or the Department to contact the Department after receiving written notice of the decision to try to resolve the disagreement informally.

1. A request for reconsideration may be made orally or in writing by the applicant or participant. 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.
2. A request for reconsideration does not suspend the 90 day time frame for filing of appeals.

(b) Commissioner’s review. An applicant or participant who wishes to appeal a decision of the eligibility committee may request, orally or in writing, within 90 calendar days after the date of the written notice of decision, a formal review of that decision by the Commissioner of the Department. Within five calendar days, the department shall notify the applicant or participant that it has received the request. 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.

1. The appeal process shall include assistance by staff of the Department, as needed, to the applicant or participant to initiate and participate in the appeal. Applicants and participants shall not be subject to retribution or retaliation for appealing Commissioner’s decision.
2. If an applicant or participant files an appeal with the wrong department, the Department shall notify the applicant or participant in writing in order to acknowledge the appeal. The

written acknowledgement shall explain that the issue has been forwarded to the correct department, identify the department to which it has been forwarded, and explain that the appeal will be addressed by that department. This does not extend the deadline by which appeals must be determined.

3. Applicants or participants may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal shall be acknowledged by the Department in writing within 5 calendar days.

4. The applicant or participant has the right to participate in person, by telephone or in writing in the Commissioner's review. Applicants or participants may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file prior to the review.

5. The applicant or participant shall be notified as soon as the Commissioner's review is scheduled. Commissioner's reviews shall be held during normal business hours and, if necessary, the review shall be rescheduled to accommodate individuals wishing to participate. If a scheduling or re-scheduling results in exceeding the 45 calendar day limit (see below), an automatic 14 calendar day time extension is effective. If a review 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 applicant or participant.

6. Appeals shall be decided and written notice sent to the applicant or participant within 45 calendar days of receipt of the appeal. 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 calendar days by request of the applicant or participant or by the Commissioner if the extension is in the best interest of the applicant or participant. If the extension is at the request of the Commissioner, it must give the applicant or 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 applicant or participant or the Commissioner is 59 calendar days.

(c) Expedited Appeal Requests. An applicant or participant may request an expedited appeal in emergent situations in which the participant indicates that taking the time for a standard resolution could seriously jeopardize his or her life or health or ability to attain, maintain, or regain maximum function.

1. Requests for expedited appeals may be made orally or in writing with the Department for any Department actions subject to appeal. The Department shall not take any punitive action against a participant who requests an expedited resolution.

2. If the request for an expedited appeal does not meet the criteria and is denied, the Department shall inform the participant that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45 day time frame. Notice of the denial for an expedited appeal shall be communicated orally to the participant within three (3) working days and followed up within two (2) calendar days with a written notice.

3. If the expedited appeal request meets the criteria for such appeals, it must be resolved within three (3) working days. The written notice for any expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the participant's right to request a fair hearing if not already requested.

(d) Financial Eligibility Determinations. If an applicant or participant files an appeal regarding only a Medicaid financial eligibility or premium determination, the Department shall forward it to the Department for Children and Families ("DCF"), Economic Services Division. The Department shall then notify the applicant or participant in writing that the issue has been forwarded to and will be resolved by DCF.

(e) Notices, Continuation of Services, Participant Liability for Service Costs. In cases involving a termination or reduction of service(s), the notice of decision must be mailed at least eleven (11) days before the change will take effect. Where the decision was adverse to the applicant or participant, the notice shall inform the applicant or participant when and how to file an appeal. In addition, the notice must inform the participant that he or she may request that covered services be continued without change as well as the circumstances under which the participant may be required to pay the costs of those services pending the outcome of any Commissioner's review or fair hearing.

1. If requested by the participant, services shall be continued during an appeal under the following circumstances:

- i. The appeal was filed in a timely manner, meaning before the effective date of the proposed action;
- ii. The participant has paid any required premiums in full;
- iii. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan;
- iv. Any applicable annual plan of care or service authorization has not expired at the time the appeal is filed; and
- v. The services were authorized by the eligibility committee and the original period covered by the authorization has not expired.

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

- i. The participant withdraws the appeal;
- ii. Any limits on the cost, scope or level of service have been reached;
- iii. The Commissioner issues a decision adverse to the participant, and the participant does not request a fair hearing within the applicable time frame;
- iv. A fair hearing is conducted and the Human Services Board issues a decision adverse to the participant; or

3. Participants may waive their right to receive continued services pending appeal.

4. Continuation of services without change does not apply when the appeal is based solely on a reduction or elimination of a service required by federal or state law or rule affecting some or all participants, or when the decision does not require the minimum advance notice.

(f) Participant Liability for Cost of Services. 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.

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

(g) Appeals Regarding Proposed Services. The Department is not required to provide a new service or a health service that is not a Medicaid-covered service while an appeal or fair hearing determination is pending. If an appeal is filed regarding a denial of service eligibility, the Department is not required to initiate service delivery.

(h) Fair hearing. An applicant or participant may use the internal Commissioner's review and be entitled to a fair hearing before the Human Services Board. Appeals to the Human Services Board are conducted pursuant to 3 V.S.A. §3091 and rules adopted by the Board.

1. A participant who wishes to obtain a fair hearing must request it within 90 days of the initial decision, or, if an internal review is requested, within 30 days of the date of the Commissioner's notice of decision.
2. If the participant's original request for an appeal was filed before the effective date of the adverse action and the participant has paid in full any required premiums, the participant's services will continue consistent with subsection (e), above.
3. Applicants and participants have the right to file requests for fair hearings related to eligibility and premium determinations. DCF shall retain responsibility for representing the State in any fair hearings pertaining to such eligibility and premium determinations.

(i) Grievances. A participant may file a grievance orally or in writing. A grievance must include a clear statement by the participant that a written response is requested from the Department.

1. A participant or his/her representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Staff members shall assist a participant or his/her representative if the participant requests such assistance.
2. Written acknowledgement of the grievance shall be mailed within five (5) calendar days of receipt by the Department. If the Department decides the issue within the 5 day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases.
3. Participants or their representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal shall be acknowledged by the Department in writing within five (5) calendar days.

4. All grievances shall be addressed within 90 calendar days of receipt. 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 the decision, and the disposition. If the response is adverse to the participant, the notice must also inform the participant of his or her right to initiate a grievance review with the Department as well as information on how to initiate such review.

5. If the grievance is decided in a manner adverse to the participant, the participant may request a review by the Department within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

i. The Department shall acknowledge grievance review requests within five (5) calendar days of receipt.

ii. The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The participant shall be notified in writing of the findings of the grievance review.

iii. Although the disposition of a grievance may not be appealed to the Human Services Board, the participant may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V. S. A. §3091 (a).

iv. The Department and any part of the MCO receiving funds under the Global Commitment for Health shall be responsible for resolving grievances initiated under these rules.

113. PROGRAM EVALUATION

(a) Annual survey. Participants and personal assistants will be surveyed annually to help the Department identify program strengths and weaknesses, including training needs.

(b) Annual meetings. The Department will meet informally with participants and their representatives, as well as with the regional and state level eligibility committees, on at least an annual basis to assess how to improve ways of providing attendant services. The Department will convene a conference biannually, which will include participants, attendants and policymakers.

114. GENERAL FUND POLICY

To attain a balance between the unmet attendant services' needs of participants in the general fund services and the unmet attendant services needs of persons on the general fund services' waiting list, the Department shall use up to 75% of general funds made available by attrition to meet the unmet need of participants in the general fund services, and it shall reserve 25% of such funds for the purpose of admitting new persons to the general fund services.