Choices for Care – DRAFT version 3/1/19

7.102 Choices for Care (XX/XX/2019, GCR 19-XXX)

7.102.1 Definitions

For the purposes of this rule, the term: (NOTE: Definitions have been cross-walked with HCAR definitions.)

(a) **"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. (NOTE: Medicaid rules exclude personal hygiene.)

(b) **"Adult Day Services"** means a range of health and social services provided at a location that has been certified by DAIL.

(c) **"Adult Family Care" (AFC)**, also known as "shared living" means 24-hour care and supervision provided by an approved unlicensed home provider, limited to a maximum of two individuals in each setting, and managed by an agency authorized by DAIL.

(d) **"Applicant"** means an individual who has submitted a Choices for Care application and whose eligibility status is pending.

(e) **"Assistive Devices and Home Modifications"** means funds that may be used to acquire commercial or off the shelf assistive device items, make physical adaptations to the home or purchase assistive technology which may be a piece of equipment or product system. Purchases made with these funds must ensure the individual maintains or improves functional abilities and that it supports the health, safety and wellbeing of the individual.

(f) **"Authorized Agency"** means an agency authorized by DAIL to provide and arrange for Adult Family Care to eligible participants.

(g) **"Individualized Budget"** means a dollar amount that has been authorized by DAIL for long-term services and supports to a participant who self-directs their Choices for Care services in the home-based setting.

(h) **"Behavioral Symptoms"** means behavior that is severe, frequent and requires a controlled environment to provide continuous monitoring or supervision.

(i) **"Case Management"** is a home-based service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes. Case Management Services assist DAIL in monitoring the quality, effectiveness and efficiency of CFC services. (NOTE: This matches the current Case Management Certification Standards. Look at DS, TBI, CM Standards to align.)

(j) **"Commissioner"** means the Commissioner of the Department of Disabilities, Aging and Independent Living.

(k) **"Companion/Respite"** means a home-based service that provides non-medical supervision and socialization for participants as determined by the needs of the individual, and which is limited in combination with Respite care.

(l) **"Controlled Environment"** means an environment that provides continuous care and supervision.

(m) **"DAIL"** means the Department of Disabilities, Aging and Independent Living.

(n) **"Date of Application"** means the date that an application is received by the Department of Vermont Health Access (DVHA).

(o) **"Eligibility Groups"** means the groups of people who are found to meet the eligibility criteria for the Highest, High, or Moderate Needs groups.

(p) **"Enhanced Residential Care"** means a 24-hour package of services provided to individuals residing in a licensed Residential Care Home, Assisted Living Residence or other state-licensed facility that has been approved by the DAIL to provide these services.

(q) **"Enrolled"** means that an applicant has been found eligible, has been assigned to an eligibility group, and is authorized to receive services.

(r) **"Flexible Choices"** means a home-based High and Highest Needs Group service option that allows an eligible consumer or surrogate employer to manage a flexible budget.

(s) **"Flexible Funds"** means a home-based Moderate Needs Group service option that provides access to a limited amount of funds that may be used to purchase needed goods or services.

(t) **"High Needs Group"** means participants who have been found to meet the High Needs Group clinical eligibility criteria and have been authorized to receive services.

(u) **"Highest Needs Group"** means participants who have been found to meet the Highest Needs Group clinical eligibility criteria and have been authorized to receive services.

(v) **"Home-Based"** means services provided to a participant who resides in their own home. This does not include a licensed facility or a formal Adult Family Care home provider.

(w) **"Home and Community-Based Services"** means all long-term services and supports provided under these regulations, with the exception of licensed facilities.

(x) **"Homemaker Services"** means a home-based service that assists a participant with Instrumental Activities of Daily Living such as shopping, cleaning, and laundry provided to help people live at home in a healthy and safe environment.

(y) **"Imminent Risk"** means there is a current threat or an event that will threaten an individual's personal health and/or safety within 45 days.

(z) **"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.

(aa) **"Instrumental Activities of Daily Living"** (IADLs) means meal preparation, medication management, telephone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment. (NOTE: Medicaid Covered Services Rules – 7406.1 (D) includes personal hygiene as an IADL)

(bb) **"Fiscal/Employer Agent (F/EA)"** means an organization that contracts with the State to provide assistance to eligible participants with payroll, taxes, and other financial management tasks for consumer or surrogate-directed self-managed home-based services.

(cc) **"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. (Check HCAR 8.100 for consistency.)

(dd) **"Long-Term Services and Supports"** is a general term referring to services covered by the Choices for Care 1115 Medicaid Waiver as described in these regulations.

(ee) **"Moderate Needs Group"** means participants who have been found to meet the Moderate Needs Group eligibility criteria and who have been authorized to receive services.

(ff) **"Participant"** means an individual for whom services have been authorized in accordance with these regulations.

(gg) **"PASARR"** means Pre-Admission Screening and Resident Review (PASRR) that is a federally required process (Omnibus Budget Reconciliation Act of 1987) to prevent individuals with mental illness, intellectual disability, or a related condition from being admitted to nursing facilities until a full assessment is made and the least restrictive, most appropriate person-centered services are recommended to meet the individual's medical and disability-related needs.

(hh) **"Person-Centered Planning"** means a process supporting the participant in accordance with 42 CFR § 441.301(c)(1) that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities and which involves families, friends, and professionals as the individual desires or requires.

(ii) **"Personal Care"** means assistance to participants with ADLs and IADLs that is essential to the individual's health and welfare. (NOTE: Medicaid rule 7406.1 (F) defines personal care as "medically necessary" and applies to children's services.)

(jj) **"Personal Emergency Response Systems (PERS)"** means electronic devices that enable participants to secure help in an emergency and provided by a vendor that has been authorized by DAIL.

(kk) **"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.

(ll) **"Provider"** means any individual, organization, or agency that has been authorized by DAIL to provide Long-Term Services and Supports and has enrolled as a Vermont Medicaid provider.

(mm) **"Provider Qualifications"** means the requirements established by DAIL for providers of specific services, including any regulations pertaining to each provider.

(nn) **"Quality Management"** means a set of integrated tools and practices used to maximize its effectiveness, efficiency and performance, with a primary focus on participant outcomes. All Choices for Care providers agree to participate in quality management activities as defined by DAIL.

(oo) **"Reimbursement"** means payment made by Vermont Medicaid to a provider for the provisions of services.

(pp) **"Resists Care"** means a participant's behavior that prevents or interferes with the provider performing or assisting with ADLs for the participant and the resistance leads to significant consequences such as malnutrition, skin breakdown, dehydration, constipation and weight loss etc. This does not include instances where the individual has made an informed choice not to follow a care plan.

(qq) **"Respite Care"** means alternate caregiving arrangements to facilitate planned short term and time-limited breaks for unpaid caregivers, and which is limited in combination with companion care.

(rr) **"Service Authorization"** means a communication through which services are authorized by DAIL, which guides the delivery of services and Medicaid payment.

(ss) **"Service Standards"** means the requirements established by DAIL for the delivery of specific services.

(tt) **"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.

(uu) **"Variance"** means an exception to or exemption from these regulations granted by DAIL as allowed under applicable statute and regulation.

(vv) **"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.

(ww) **"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.

7.102.2 Covered Services (NOTE: New format but matches current regulations information.)

Choices for Care services approved for eligible participants include:

Setting	**Service**	**Eligibility Group**	**Maximum**

Choices for Care

Home-Based	Adult Day	High/Highest Needs	Up to 12 hours per day
		Moderate Needs	Up to 30 hours per week
	Assistive Devices & Home Modifications	High/Highest Needs	Up to the current rate on file
	Case Management	High/Highest Needs	Up to the amount as established by the DAIL
		Moderate Needs	
	Companion/Respite	High/Highest Needs	Up to 720 hours per calendar year
	Flexible Funds	Moderate Needs	Up to the amount of the individualized budget
	Homemaker	Moderate Needs	Up to 6 hours per week
	Personal Care	High/Highest Needs	Up to the amount of the participant's authorized service plan or individualized budget. IADLs shall not exceed 4.5 hours/week.
	Personal Emergency Response	High/Highest Needs	Up to the current rate on file
	Self-Directed Services: Flexible Choices, Consumer and Surrogate Directed Personal Care, Respite, Companion	High/Highest Needs	Up to the amount of the individualized budget
Adult Family Care	Case management, personal care, respite, assistive devices/home modifications, community participation in a shared living setting.	High/Highest Needs	Up to the authorized tier rate on file
	Adult Day	High/Highest Needs	Up to 12 hours per day
Enhanced Residential Care	Bundled daily rate to cover 24-hour services in an approved Vermont licensed care home	High/Highest Needs	Up to the authorized tier rate on file
Nursing Facility	Bundled daily rate to cover 24-hour services in a facility licensed according to the 42 CFR § 483, Subpart B and Vermont regulations	High/Highest Needs	Current rate on file

Individual service standards are managed by DAIL and can be found in the Choices for Care Program Manuals and align with the 1115 Global Commitment to Health waiver Special Terms and Conditions.

Choices for Care service rates and codes may be found on the Adult Services Division website or by contacting the Vermont Medicaid fiscal agent.

(NOTE: Medicaid payment reform allows these limitations to be waived through the contracting process.)

7.102.3 Eligibility (NOTE: From current CFC regulations.)

(a) High/Highest Needs Group:

(1) Individuals who wish to enroll in the Choices for Care Highest or High Needs Groups shall complete an application and file it with the Department of Vermont Health Access.

(2) Applicants must be a Vermont resident age 18 years or older and meet both clinical and financial eligibility for services based on criteria set for each eligible group.

(3) Applicants applying for Choices for Care in a nursing facility setting must also receive a PASARR screening according to federal regulations. Applicants who do not pass a Step II PASARR screening are not eligible to receive Choices for Care services in a nursing facility setting.

(4) DAIL shall make a decision regarding clinical eligibility for Choices for Care within 30 days of receiving the application.

(5) DAIL shall review clinical eligibility once per year, at minimum, for all active participants.

(6) Clinical Eligibility:

(A) Highest Need clinical eligibility requires at least one of the following:

(i.) 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.) 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
Symptom
Verbally Aggressive Behavior
Physically Aggressive Behavior Behavioral

(iii.) 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
IV Medications
End Stage Disease
Ventilator/ Respirator
Naso-gastric Tube Feeding
Parenteral Feedings

2nd or 3rd Degree Burns	Suctioning

(iv.) 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

(v.) DAIL shall enroll an individual in the Highest Needs Group when it 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. DAIL may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

1. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse),
2. Loss of living situation (e.g. fire, flood),
3. 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
4. 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.).

(B) High Need clinical eligibility requires at least one of the following:

(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 require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a daily basis and 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 | Suctioning
Medication Injections | End Stage Disease
Parenteral Feedings | Severe Pain Management
Tube Feedings

(vi.) Participants whose health condition shall worsen if services are not provided or if services are discontinued upon reassessment due to clinical ineligibility.

(vii.) Participants whose health and welfare shall be at imminent risk if services are not provided or if services are discontinued upon reassessment due to clinical ineligibility.

(C) Moderate Needs Group clinical eligibility requires at least one of the following:

(i.) Individuals who require supervision or any physical assistance three or more times in seven 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.) Participants whose health condition shall worsen if services are not provided or if services are discontinued upon reassessment due to clinical ineligibility.

(7) Financial Eligibility

(A) High/Highest Need Group financial eligibility follows the Medicaid rules for Long-Term Care eligibility found in the Health Benefits, Eligibility and Enrollment (HBEE) rules on the DVHA website.

(B) Moderate Needs financial eligibility is based on self-reported income and resources: (NOTE: From current CFC regulations.)

(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. 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 Vermont 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).

(ii) Countable resources are included in the income eligibility determination process. Countable resources include cash, savings, checking, certificates of deposit, money markets, stocks, bonds, trusts 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. Resource disregards are applied as an adjustment to resource limits. Details may be found in the Choices for Care Moderate Needs Program Manual.

(ii.) SSI Eligibility Rules:

If there is a question about whether or not resources or income are countable under this section, DAIL shall apply the SSI-related community Medicaid financial eligibility rules under HBEE.

(iii.) Post-eligibility rules related to transfer of assets and patient share shall not apply to individuals enrolled in the Moderate Needs Group.

7.102.4 Wait Lists (NOTE: From current CFC regulations.)

(a) Highest Needs Group:

Enrollment in the Highest Needs Group shall not be subject to a wait list.

(b) High Needs Group:

Enrollment in the High Needs Group shall be limited by the availability of funds as appropriated by the Vermont Legislature.

(1) 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 program as funds become available, according to procedures established by the DAIL and implemented by regional Choices for Care teams. The Choices for Care teams shall use professional judgment in managing the wait list and admitting applicants 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.

(2) Individuals whose names are placed on a wait list shall be sent written notice that their name has been placed on the list, which shall include information about how the wait list operates.

(3) When an applicant's circumstances present a clear emergency, and DAIL staff is unavailable, the individual may be admitted to services without prior approval from the DAIL. Under these circumstances, DAIL 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.

(4) 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

(5) Participants who are enrolled in the Highest Needs group and subsequently meet the High Needs group eligibility criteria shall be enrolled in the High Needs group and continue to be eligible to receive services.

(6) DAIL 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.

(7) 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.

(c) Moderate Needs Group:

Enrollment in the Moderate Needs group shall be limited by the availability of funds as appropriated by the Vermont Legislature.

(1) If funds are unavailable at the local Moderate Needs provider of services, the names of any eligible applicants shall be put on a waiting list by the applicable Moderate Needs provider.

(2) Applicants on a waiting list shall be admitted to services using a priority system that utilizes the applicant's assessed risk factors as established by the DAIL in policy and procedures. Applicants who are categorically eligible for traditional Medicaid shall receive priority for purposes of enrollment. (NOTE: New language. Confirming with CMS that updating this wait list protocol is ok for the GC STC attachment.)

7.102.5 Qualified Providers

(a) All Choices for Care providers must be pre-approved by the DAIL and shall abide by applicable laws, regulations, policies and procedures. The DAIL may terminate the provider status of an agency, organization, or individual that fails to do so. Choices for Care provider enrollment information may be found on the Adult Services Division website.

(b) All Choices for Care (CFC) provider agencies shall comply with all program standards, including the Universal Provider Standards, as well as program limitations as set forth in the program manual. This includes compliance

with federal Home and Community-Based Services (HCBS) regulations regarding person-centered planning, conflict of interest and setting requirements (42 CFR § 441 Subpart G)

7.102.6 Authorization Requirements

(a) Eligibility Notification: All eligible applicants will receive a Notice of Decision that communicates the financial eligibility for Medicaid and program eligibility for Choices for Care.

(b) DAIL Service Authorization: All eligible participants (excluding nursing facility) will receive a service authorization notification from the DAIL authorizing the service volume and start dates.

(c) The DAIL may grant variances to these regulations. (NOTE: From the current CFC regulations.)

(1) Variances may be granted upon determination that the variance will otherwise meet the goals of the Choices for Care waiver and the variance is necessary to protect or maintain the health, safety or welfare of the individual.

(2) The need for a variance must be documented and the documentation presented at the time of the variance request.

(3) Applicants, participants, and providers may submit requests for a variance to DAIL at any time. Variance requests shall be submitted in writing, and shall include:
(A) A description of the individual's specific unmet need(s);
(B) An explanation of why the unmet need(s) cannot be met; and
(C) A description of the actual/immediate risk posed to the individual's health, safety or welfare.

(4) In making a decision regarding a variance request, DAIL may require further information and documentation to be submitted. DAIL also may require an in-home visit by DAIL staff. DAIL shall review a variance request and forward a decision to the individual, his or her legal representative, if applicable, and to the provider(s). DAIL 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.

(5) Retroactive Requests: Approved variances are effective no earlier than the date the request was received at DAIL. Retroactive requests will be considered only when a precipitating event necessitated an immediate increase of services exceeding the currently approved volume of services. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility admission. Retroactive requests must be submitted to DAIL in accordance with DAIL policy and procedure.

7.102.7 Terminations

A participant may voluntarily withdraw from the Choices for Care program at any time for any reason. Participants may be terminated from the Choices for Care program or from individual services for the following reasons:
(NOTE: From CFC Program Manual.)

(a) Clinical ineligibility.

(b) Financial ineligibility.

(c) Participant death.

(d) Stay out of state-exceeding 30 continuous days.

(e) The participant no longer requires Choices for Care services to remain in setting of choice.

(f) Provider termination of services: In limited situations, a CFC provider may terminate services for one or more of the following reasons:
   (1) Non-payment of patient share by the individual or legal representative;
   (2) The participant, primary caregiver or other person in the home has exhibited behavior that presents a risk of harm to agency staff such as physical abuse, sexual harassment, threatening behavior or verbal abuse;
   (3) Involuntary discharge from residential setting (ERC or nursing facility) according to DLP Licensing Regulations; or
   (4) Involuntary move from an Adult Family Care (AFC) setting according to the Choices for Care program manual.

7.102.8 Non-Covered Services (NOTE: From current CFC regulations.)

(a) 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 Medicare, Medicaid and private insurance coverage.

(b) Individuals whose primary need for services is due to developmental disability or mental illness shall not be eligible for Choices for Care services.

7.102.9 Appeals, Grievances and Fair Hearings

Rules governing internal appeals, grievances and State fair hearings on Medicaid services are fully set forth in Health Care Administrative Rule (HCAR) 8.100. Rules governing fair hearings and expedited administrative appeals regarding eligibility determinations are fully set forth in Health Benefit Eligibility and Enrollment (HBEE) Rules Part Eight. Additional guidance may be found in the Choices for Care Program Manual.