Choices for Care Regulations Summary - 2019

The 2009 Choices for Care regulations are being revised into the new Health Care Administrative Rules (HCAR) format. We do not expect significant changes but will modernize the text and better align with Medicaid rules in a cleaner format. We are also proposing to update the Moderate Needs waitlist policy from chronological to a priority system (like our current high needs wait list process), as long as the Centers for Medicare and Medicaid Services (CMS) says it's OK to do so without an amendment to Vermont's Global Commitment waiver.

The general timeline, if we stay on track, is that we expect to send a draft version of the regulations to stakeholders for "informal" feedback in March 2019 and then file a revised draft to ICAR (Interagency Committee on Administrative Rules) in May 2019. Once the rules have been filed, then there will be a formal process that includes a 30-day opportunity for public input and a public hearing with LCAR (Legislative Committee on Administrative Rules). Stakeholders will be notified when the rules are filed. The entire process is expected to be complete in late summer or fall 2019.

Summary of Draft Changes by Section

1. Definitions

- Adapted format and modernized text.
- Removed unnecessary definitions.
- Combined Assistive Devices & Home Modifications definition and slightly expanded language to allow for future creative solutions.

2. Covered Services

- New format with same services as current regulations
- Eliminates reference to maximum caps for case management services to allow for ease of future system adaptations.
- Updated the Flexible Choices/Flexible Funds services cap to accurate reflect change from hours to individualized dollar budgets.

3. Eligibility

- Same clinical eligibility language as current rules.
- Same Moderate Needs financial eligibility language as current regulations with some modification for clarity around resources.
- Added reference LTC Medicaid rules.

4. Wait Lists

- High Needs – same as current regulations.
- Moderate Needs – added draft changes to wait list language changing from chronological to priority/risk-based.

5. Qualified Providers

- Same language from current regulations.
- Added Universal Provider Standards from current program manual.

6. Authorization Requirements

- New language regarding the DVHA Notice of Decision information. (no operational change)
- New language regarding the DAIL service authorization notice. (no operational change)
- Same variance language from current regulations.

7. Terminations

- Added language from current program manual.
- Reasons for termination aligns with home health regulations.

8. Non-covered services

- Same language from current regulations about non-duplication of services.
- Same language from current regulations about DS and MH services eligibility.

9. Grievance and appeals

- New language to match federal Medicaid grievance/appeals rules.