ATTENDANT SERVICES PROGRAM
Regulations

February 15, 2013

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

This rule is available upon request in alternative formats

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

POLICY

It is the policy of the Department of Disabilities, Aging and Independent Living to make Vermont the best state in which to grow old or to live with a disability ~ with dignity, respect and independence. 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.

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.

ATTENDANT SERVICES PROGRAM REGULATIONS

10l. 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 gain or retain independence, they are a necessary component of any service system with that goal. It is the purpose of the Attendant Services Program to assist individuals to gain or retain 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; or
4. failure to act in a timely manner when required by state rule.

(b) "Activities of daily living" (ADL) means the assistance with activities required for eligibility for the Attendant Services Program, which include:

1. dressing and undressing;
2. bathing and showering;
3. grooming;
4. toileting;
5. transferring;
6. bed mobility;
7. range of motion exercises;
8. positioning;
9. eating; and
10. ambulation and mobility in and around the home.

(c) "Adult" means an individual at least 18 years old.

(d) "Agent" means an individual who acts on behalf of the participant to provide the physical assistance needed to sign employee time sheets. An agent is not permitted to act in lieu of the participant to direct his or her own care. If a participant has a power of attorney but can no longer direct that individual, the individual cannot act as an agent for the participant.

(e) "Appeal" means a request for an internal review of an action by the Department.

(f) "Applicant" means an individual who has submitted to the Department a completed application for attendant services.

(g) "Attendant services" means assistance with personal care (including dressing, bathing, shaving, and grooming), eating, meal preparation, and ambulation. 33 V.S.A. §6321(a).

(h) "Department" means the Department of Disabilities, Aging and Independent Living.

(i) "Designee" means a person who is named or chosen by the applicant to complete and/or submit the ASP application on the applicant's behalf, such as a person holding a Power of Attorney, legal guardian or family member.

(j) "Eligible for Medicaid" means that an individual meets the requirements for community Medicaid. Individuals who have a "spend down" requirement are considered to be eligible for Medicaid for purposes of determining eligibility for the Attendant Services Program.

(k) "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.

(l) "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.)

(m) "Infant and child care" means bathing, dressing and feeding a non-Medicaid participant's infant or child to the extent that and only so long as the child cannot perform these tasks.

(n) "Instrumental Activities of Daily Living" (IADL) means physical assistance with:

1. light housekeeping;
2. household maintenance;
3. laundry;
4. shopping;
5. transportation;
6. meal preparation; and
7. medication management.

For the purpose of the Attendant Services Program, IADL also includes physical help with 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 funds services but cannot be reimbursed under Medicaid PDAC); care of support animals such as seeing-eye dogs and hearing-ear dogs; guiding a participant who is blind or visually impaired from place to place; general care and cleaning of adaptive tools and equipment; and managing personal finances and mail, including paying bills and writing checks.

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

(p) "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.

(q) "Permanent and severe disability" means a physical disability that is anticipated to last the duration of the individual's life that limits the individual's physical ability to perform activities of daily living (ADLs) and that is directly associated with a need for physical assistance with ADLs.

(r) "Personal assistant" means a person who, for compensation, provides attendant services.

104. APPLICATIONS

Application forms for the Attendant Services Program shall be available on the Department's website, 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. For an individual to be considered for the Program, the Department must receive an application from the applicant or his or her designee.

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), be an adult resident of Vermont in need of attendant services to gain or retain independence, and meet the requirements listed in subsection f below.

(b) Personal Services. To be eligible for services under Personal Services, an individual shall be actively enrolled on one of the Attendant Services Programs but no longer able to direct his or her own care and shall:

1. Have a disability;
2. Be eligible to receive community Medicaid; and
3. Need attendant services for at least one activity of daily living or meal preparation.

(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;
3. Be capable of directing his or her attendant care services; and
4. Be ineligible for any other Medicaid or state -funded programs.

(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 community 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;
5. Be capable of directing his or her attendant care services; and
6. Be ineligible for any other Medicaid or state-funded programs.

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

(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.

106. SERVICES

Program funds are available to pay for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for eligible individuals. Assistance with IADLs shall be limited to a maximum of 50% of the total award.

107. 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 Department to be needed by the applicant or participant.

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

(d) 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.

(e) 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 may consider the specific circumstances of the participant in deciding whether to continue such payment.

(f) Special Circumstances. Depending on availability of funds, a temporary increase in hours may be approved for a participant to meet an immediate need for additional attendant services caused by events such as recovery from an illness or a sudden change in other services and supports.

108. PARTICIPANTS

(a) Oversight of personal assistants. Participants, except for those receiving services under Personal Services, shall direct the provision of their attendant services.

1. 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.

2. A participant in Personal Services shall 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 all of the requirements listed below regarding the personal assistant(s). 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.

3. With respect to Group Directed Services, the group itself shall incorporate these requirements in accordance with its own governing rules.

4. Participants are responsible for carrying out all of the following tasks:
   i. Hiring, training, supervision, and firing of personal assistants;
   ii. Establishing work schedules;
   iii. Approving personal assistant time reports and submitting them to the Department or the designated payroll agent;
   iv. Assuring that all benefits to which the personal assistant is entitled are provided;
   v. Keeping payroll records; and
   vi. 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, insurance, conditions of work, and firing.

(e) Notice of changes. Participants or their agent or guardian, if applicable, 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, or agent, if any;

2. Plans to leave the State temporarily or permanently; or actual absences from the State for more than 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 home health agency service, or a homemaker service); and/or

7. Changes in need for attendant services (including changes in disability status, functional capacity, medical condition, or living situation that have a substantial impact on the need for attendant services).

(f) Program agreement. Participants shall indicate their agreement with the conditions of their participation in the program by signing an Attendant Services Program Agreement.

109. PERSONAL ASSISTANTS

(a) Who. A participant may choose his or her personal assistant(s). 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 whose name appears on a Registry for the abuse, neglect, or exploitation of a child or a vulnerable adult or who has a criminal conviction as set forth in the Department's Background Check Policy shall not be reimbursed for attendant care services.

3. An attendant shall not be permitted to provide attendant services to a participant for more than eight hours a day.

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

(c) Training. Personal assistant training is 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) Special circumstances.

1. Change or hiring of a personal assistant. When there is a change in personal assistant or the hiring of a replacement assistant for a participant, the Department may pay for the incoming personal assistant as well as the outgoing personal assistant for up to three days of the daily awarded time for the purposes of training. In order to obtain such payment, the participant shall provide to the Department prior written notice that the personal assistant has either resigned or been fired and 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 General Funds, if available, 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.

110. CONFIDENTIALITY

To the extent required by law, the Department 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. Records may be disclosed with the written consent of the applicant or participant in the context of an administrative or judicial proceeding involving the applicant or participant, or upon order of a court.

111. APPEALS

The Attendant Services Medicaid 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 Department of Vermont Health Access, as a Managed Care Entity ("MCE") 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.

A managed care entity (or MCE) means 1) the Department of Vermont Health Access ("DVHA"); 2) any State department with which DVHA 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) DA/SSA; and 4) any contractor performing service authorizations or prior authorizations on behalf of the Department.

(a) Internal Appeals. 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 service 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. 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.

(b) Commissioner's review. An applicant or participant who wishes to appeal a decision of the Department may request, orally or in writing, within 90 calendar days after the date of the written notice of decision, a formal internal 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 internal 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 internal appeals orally or in writing at any time. If an internal 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 internal 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 internal 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 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. Internal 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 internal 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, patient share 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 Medicaid 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 internal review or fair hearing.

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

   i. The appeal or request for fair hearing 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 or fair hearing involves the termination, suspension or reduction of a previously authorized service plan; and
   iv. Any applicable annual plan of care or Medicaid service authorization has not expired at the time the appeal is filed.

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

   i. The participant withdraws the appeal or request for fair hearing;
   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
   v. The original Medicaid service period has expired.

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

4. Continuation of Medicaid or other services without change does not apply when the appeal or request for a fair hearing 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.

5. The Department is not required to provide a new service or any 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.

(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 or request for fair hearing, whichever is later.

1. The Department 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) 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.

112. 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.

(a) 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.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

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

2. 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.

3. 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).

4. The Department 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 stakeholders, on at least an annual basis to assess how to improve ways of providing attendant services.

(c) Advisory Committee. The Department will meet a minimum of two times a year with a

participant/stakeholder advisory committee. One purpose of the committee will be to review and provide feedback on an anonymous sample of eligibility determinations.