

**Choices for Care language in 2005 Acts and Resolves No. 56, Sec. 1,
as amended by 2007 Acts and Resolves No. 65, Sec. 112a, by 2008 Acts and Resolves
No. 192, Sec. 5.207, and by 2012 Acts and Resolves No. 139, Sec. 51(q)**

Sec. 1. LONG-TERM CARE MEDICAID 1115 WAIVER

(a) The department of aging and independent living shall implement the long-term care Medicaid 1115 waiver by rule in fiscal year 2006 upon approval from the Centers for Medicare and Medicaid Services. The rules for operation of the 1115 waiver shall include criteria and standards for eligibility, levels of assistance, assessments, and reviews, and the appeal and fair hearing process. Final proposed rules filed pursuant to this act shall be filed with the chair of the health access oversight committee created in Sec. 13 of No. 14 of the Acts of 1995. If the long-term care Medicaid 1115 waiver is included in a broader Medicaid waiver, including the “global commitment,” the provisions of this act shall apply to the relevant portions of that waiver.

(b)(1) Outside the legislative session, the health access oversight committee shall have oversight for the development, implementation, and ongoing operation of any long-term care Medicaid waivers applied for and received by the agency of human services.

(2)(A) ~~The secretary of human services shall report to the committee upon its request and annually to the general assembly by January 15 [Deleted in 2012].~~

(B) The department shall submit quarterly reports to the general assembly or the health access oversight committee about the utilization of services and expenses under Choices for Care. The reports shall also include a comparison of actual expenditures to estimated expenditures and projected expenditures for the remainder of the fiscal year.

(c)(1) If the long-term care Medicaid 1115 waiver is approved, the department shall implement the waiver in such a manner as to assure that any individual receiving services on the date the waiver becomes effective shall continue to receive appropriate services. The process for reassessing entitlement for services for individuals under this subdivision is as follows:

(A) The individual shall first be assessed under the new level of care criteria established under the waiver to determine entitlement to services.

(B) If the individual is no longer entitled to services under the new criteria, the individual shall be assessed under the Guidelines for Nursing Home Eligibility adopted in April 1997, which is the level of care criteria in effect prior to the waiver. If the individual is entitled to services under the Guidelines, the individual shall continue to receive services.

(C) If the individual is not entitled to services under subdivision (A) or (B) of this subdivision (1), the individual shall no longer receive services, but shall be treated appropriately under the new rules.

(2) The department shall adopt by rule a process by which an individual who is eligible for, but not entitled to, services and who is in the high needs group as defined by the waiver may apply for an exception to the entitlement rule if the individual has a critical need for long-term care services due to special circumstances.

(3) The department shall develop and maintain waiting lists both of applicants categorized by need level for whom there is insufficient funding to provide services under the long-term care Medicaid 1115 waiver and of individuals applying for long-term care services under state-funded programs.

(d) The department shall adopt by rule a process by which individuals entering the long-term care system are assessed and informed of their options prior to entering a nursing home. The rule shall ensure that the assessment and information is provided in a timely manner so as not to delay discharges from hospitals and shall include provisions for emergency admissions to nursing homes.

(e) The department shall prioritize the provision of homemaker services to individuals who have high needs as defined under the long-term care Medicaid 1115 waiver and are on the waiting list for long-term care services.

(f) If a modification in the rules is necessary outside the legislative session to ensure that the funding for entitled individuals is not jeopardized, the department shall file recommended modifications to the health access oversight committee. After the review and recommendation of the health access oversight committee or within three weeks of filing, whichever is earlier, the department may adopt interim changes by rule under the expedited rulemaking process set out in Sec. 27(b) of H.537 [Medicaid budget].

(g)(1) Any savings realized due to the implementation of the long-term care Medicaid 1115 waiver shall be retained by the department and reinvested into providing home- and community-based services under the waiver. If at any time the agency reappplies for a Medicaid waiver to provide these services, it shall include a provision in the waiver that any savings shall be reinvested.

(2) In its annual budget presentation, the department of disabilities, aging, and independent living shall include the amount of savings generated from individuals receiving home- and community-based care services instead of services in a nursing home through the Choices for Care waiver and a plan with details on the recommended

use of the appropriation. The plan shall include the base appropriation; the method for determining savings; how the savings will be reinvested in home- and community-based services, including the allocation between increases in caseloads and increases in provider reimbursements; and a breakdown of how many individuals are receiving services by type of service. The department shall convene a working group from its advisory council for the purpose of providing input on the advisability of seeking renewal of the waiver and how with any new waiver there can be timely reporting to providers and consumers on reinvested savings.

(h) Any funds appropriated for long-term care under the long-term care waiver authorized under this act shall be used for long-term care services to recipients. In using these funds, the department shall give priority to services to individuals assessed as high and highest needs and meeting the terms and conditions of the waiver as approved by the Centers for Medicare and Medicaid Services. Any remaining funds from the long-term care appropriation may be used for other long-term care services as defined in subsection (i) of this section. The remaining funds shall be allocated and spent in ways that are sustainable into the future and do not create an unsustainable base budget. Any funds that are not spent in the year for which they were appropriated shall be carried over to the next fiscal year.

(i) “Long-term care” means care or services received by an individual in a nursing home, or through home- and community-based services designed to assist older Vermonters and people with disabilities to remain independent and avoid inappropriate institutionalization. “Home- and community-based services” include:

(1) services funded through a long-term care Medicaid 1115 waiver;

(2) services provided to individuals with traumatic brain injury through a Medicaid waiver;

(3) services provided in residential care homes and assisted living residences;

(4) assisted community care services;

(5) attendant services;

(6) homemaker services;

(7) services funded through the Older Americans Act;

(8) adult day services;

(9) home health services;

(10) respite services for families including an individual with Alzheimer's disease;

(11) services provided by the Home Access Project of the Vermont Center for

Independent Living;

(12) programs providing meals for young people with disabilities;

(13) services provided by the Sue Williams Freedom Fund of the Vermont Center

for Independent Living;

(14) living skills services from the Vermont Association for the Blind and Visually

Impaired;

(15) services under the Program for All-Inclusive Care of the Elderly (PACE);

(16) services under the Home Share Vermont program; and

(17) transportation services.