25-P021

FINAL PROPOSED RULE # _____.

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Rules for the Designation and Operation of Home Health Agencies

/s/Kristin L. McClure _____ , on 2/18/2026

(signature) (date)

Printed Name and Title:
Kristin McClure, Deputy Secretary, Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

280 State Drive – Center Building
Waterbury, VT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

JENNEY SAMUELSON
SECRETARY

KRISTIN MCCLURE
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Sarah Copeland Hanzas, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: January 7, 2026

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Kristin McClure, Deputy Secretary, Agency of Human Services as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedures Act, 3. V.S.A § 801 et seq.

CC: KristinMcClure@vermont.gov

1. TITLE OF RULE FILING:
   Rules for the Designation and Operation of Home Health Agencies

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   25P021

3. ADOPTING AGENCY:
   Agency of Human Services; Department of Disabilities, Aging, and Independent Living

4. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Pamela Cota

   Agency: Department of Disabilities, Aging and Independent Living (DAIL)

   Mailing Address: HC 2 South, 280 State Drive
   Waterbury, VT 05671-2060

   Telephone: 802-241-0347 Fax:

   E-Mail: pamela.cota@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*:
   https://dlp.vermont.gov/survey-cert/facility-regs

5. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Stuart Schurr

   Agency: DAIL

   Mailing Address: 280 State Drive, HC 2 South, Waterbury, VT, 05671

   Telephone: 802-238-3754 Fax:

   E-Mail: stuart.schurr@vermont.gov

6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) Yes

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   1 V.S.A. § 317 (c)(1); 33 V.S.A. § 6303

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

33 V.S.A. § 6303(a) provides that the Commissioner of Disabilities, Aging and Independent Living shall adopt by rule program standards for the purpose of providing quality oversight of home health agencies. The minimum program standards must include practices to ensure confidentiality of patient records.

7. LEGAL AUTHORITY / ENABLING LEGISLATION:
(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

   33 V.S.A. § 6303

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
   The Commissioner of Disabilities, Aging, and Independent Living shall adopt by rule program standards for the purpose of providing quality oversight of home health agencies. The minimum program standards must include performance standards, quality indicators, grievance and complaint procedures, patient safety standards, consumer input mechanisms, accessibility standards, medical necessity standards, and practices to ensure confidentiality of patient records.

9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

   It is not uncommon for designated home health agencies, despite their best efforts to recruit and retain staff, to lack the necessary staffing to provide designated services, as currently defined, to all individuals who

are referred. The severe workforce shortage of personal care attendants prevents home health agencies from complying with the requirement to serve all individuals on Choices for Care who are referred for services. As a result, most agencies are operating under a variance to this requirement. The proposed rule would remove Choices for Care services, including personal care, respite, companionship, and homemaker services, which are not "home health services," from the Rule's definition of "designated services," to ensure that agencies are not held responsible for providing services that they frequently lack staffing to provide, while allowing them to continue to provide these services when they do have sufficient staff. The proposed rule makes other technical changes for clarity.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

The amendments to the Rule are necessary to address the liability faced by the designated home health agencies related to the requirement in the Rule that they provide all designated services to all individuals who are referred within the service area. Without this rule change, home health agencies could be cited for noncompliance, or they could elect to no longer provide a designated service at all in their service area.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The Agency based its decision to modify the definition of "designated services" upon the fact that most designated home health agencies are unable to comply with the requirement to provide all such services, as currently defined, due to workforce shortages. Further, aligning this definition with the current practice, in response to these realities, is reasonable.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Department of Disabilities, Aging, and Independent Living

Home Health Agencies

Area Agencies on Aging

Vermont Legal Aid, including the State Long-Term Care Ombudsman Program

Home Health patients

Choices for Care participants

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

This rule change is expected to have minimal economic impact. As a result of this change, home health agencies will no longer be out of compliance with these Rules if they are unable to provide personal care, respite, companionship, and homemaker services to those enrolled in Choices for Care. Home health agencies will continue to provide these services as they are able, as they do now. The rule change will also enable home health agencies to focus their resources on the delivery of designated services and will create an opportunity to expand the number of providers authorized to deliver these non-medical Choices for Care services to beneficiaries throughout the state.

19. A HEARING WAS HELD.

20. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 8/5/2025

Time: 12:00 PM

Street Address:

Zip Code:

URL for Virtual:
https://www.zoomgov.com/j/1605733457?pwd=31awleU2boG8JpBGcRfqMPbRoYyaNa.1

Date: 8/7/2025

Time: 12:00 PM

Street Address:

Zip Code:

URL for Virtual:
https://www.zoomgov.com/j/1603660486?pwd=Iul7qGTD4ZzwsfNjERY7UZPZ4wcG3O.1

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
8/15/2025

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

home health agencies
designation
Choices for Care
designated services

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Rules for the Designation and Operation of Home Health Agencies
2. ADOPTING AGENCY:
   Agency of Human Services; Department of Disabilities, Aging, and Independent Living
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE** .
4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE)*:
   SOS Log #19-038, Designation and Operation of Home Health Agencies, October 1, 2019

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

1. TITLE OF RULE FILING:

   Rules for the Designation and Operation of Home Health Agencies

2. ADOPTING AGENCY:

   Agency of Human Services; Department of Disabilities, Aging, and Independent Living

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Department of Disabilities, Aging and Independent Living - no impact is anticipated.

   Home Health Agencies - will no longer be out of compliance with these Rules if they are unable to provide personal care, respite, companionship, and

homemaker services to those enrolled in Choices for Care. They will continue to provide services as they are able, as they do now. The rule change will also enable home health agencies to focus their resources on the delivery of designated services and will create an opportunity to expand the number of providers authorized to deliver these non-medical Choices for Care services to beneficiaries throughout the state.

Home Health patients - no impact is anticipated.

Choices for Care participants - no impact is anticipated.

Area Agencies on Aging-no impact is anticipated

Vermont Legal Aid, including the State Long-Term Care Ombudsman Program-no impact is anticipated

4. IMPACT ON SCHOOLS:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact is anticipated.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

No impact is anticipated.

6. IMPACT ON SMALL BUSINESSES:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

No impact is anticipated.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

No impact is anticipated.

8. COMPARISON:
COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING

SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
This rule change is expected to have minimal economic impact. Agencies will continue to provide services as they are able, as they do now. Without this rule change, home health agencies could be cited for noncompliance, which could result in financial penalties, or they might choose to no longer provide a designated service at all in their service area, which would result in a loss of revenue.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
The economic impact analysis was conducted using the current understanding of home health agency rules, practices, and rates.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

1. TITLE OF RULE FILING:

   Rules for the Designation and Operation of Home Health Agencies

2. ADOPTING AGENCY:

   Agency of Human Services; Department of Disabilities, Aging, and Independent Living

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact is anticipated.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact is anticipated.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact is anticipated.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACTS RECREATION IN THE STATE:*
   No impact is anticipated.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact is anticipated.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact is anticipated.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   Not applicable

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Rules for the Designation and Operation of Home Health Agencies

2. ADOPTING AGENCY:

   Agency of Human Services; Department of Disabilities, Aging, and Independent Living

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   DAIL sought public comment from a broad range of interested parties, including the public, by posting the proposed rule on the DAIL website, sharing the proposed rule via email newsletters and social media, making announcements at the DAIL Advisory Board meeting, the Alzheimer's Commission meeting, and other stakeholder meetings, and sending the proposed rule to home health agencies, area agencies on aging, and Vermont Legal Aid through direct email and encouraging them to share with program participants. DAIL provided a variety of options through which people could share feedback on the proposed rule, including two virtual public hearings and the submission of written comments.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

AHS/DAIL worked closely with the home health agencies on the development of the proposed revisions to the Rule. DAIL's Adult Services Division Director met with the Executive Director of the VNAs of Vermont throughout 2024 to review and discuss the agencies' suggested revisions.

Once a draft of proposed revisions was completed, the Adult Services Division Director met with the following groups for feedback and discussion:

9/9/2024 - The directors of all 9 Home Health Agencies

9/10/2024 - The directors of all 5 Area Agencies on Aging

9/25/2024 - Vermont Legal Aid, including representatives from the Elder Law Project and the State Long-Term Care Ombudsman Program

The Home Health Agencies submitted written comments on 10/4/2024, and Vermont Legal Aid submitted written comments on 10/7/2024. The Area Agencies on Aging did not submit written comments.

Vermont Agency of Administration

Interagency Committee on Administrative Rules (ICAR) Minutes

Date/Time: May 12, 2025, 2:00 PM

Location: Virtually via Microsoft Teams

Members Present: Chair Nick Kramer, Diane Sherman, Jared Adler, Jen Mojo, John Kessler, and Nicole Dubuque

Members Absent: Natalie Weill, and Mike Obuchowski

Minutes By: Jen Mojo

- 2:00 p.m. meeting called to order.
- Review and approval of minutes from the April 14, 2025 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- No public comments made.
- Presentation of Proposed Rules with recommended changes on pages to follow.
    1) Rules Relating to the Closure of State Highways, Agency of Transportation
    2) Rules for Establishing Temporary Speed Limits, Agency of Transportation
    3) Regulations Governing Use of State Highways with Limited Access Facilities, Agency of Transportation
    4) Rules for the Designation and Operation of Home Health Agencies, Department of Disabilities, Aging, and Independent Living
- Other business: Due to lack of quorum, the Committee will hear the Best Management Practices for the Use of Neonicotinoid Treated Article Seeds and Neonicotinoid Pesticides Rule by Agency of Agriculture, Food & Markets at its June 9, 2025 meeting. The Committee will put this rule first on the agenda.
- Next scheduled meeting is Monday, June 9, 2025, at 2:00 p.m.
- 3:29 p.m. meeting adjourned.

To receive this information in an alternative format or for other accessibility requests, please contact:

Agency of Administration
ADM.Secretary@vermont.gov, 802-828-3322

Proposed Rule: Rules for the Designation and Operation of Home Health Agencies, Department of Disabilities, Aging, and Independent Living

Presented By: Stuart Schurr

Motion made to accept the rule by Nicole Dubuque, seconded by Diane Sherman, and passed unanimously with the following recommendations:

1) Proposed Filing – Coversheet:
    a. #8 – Change tone regarding compliance.
    b. #11 & 12 – This list includes more entities than in economic impact statement. Have sections mirror the list of entities.
    c. #12 – Recommend additional detail regarding value of liability avoidance.

2) Public Input Maximization Plan:
    a. #3 – clarify who are the service providers and community partners.

VNAs of Vermont

TO: Pamela Cota and Stuart Schurr
Department of Disabilities, Aging, and Independent Living
Agency of Human Services

FROM: Jill Mazza Olson, Executive Director

DATE: August 8, 2025

RE: Public Comment on 25P021
Proposed Rule Change - Designation and Operation of Home Health Agencies

Dear Pamela Cota and Stuart Schurr,

Thank you for the opportunity to comment on 25P021 Proposed Rule Change - Designation and Operation of Home Health Agencies.

Comments on Individual Provisions

4.7(f): We support this change which comports with the law that eliminated the "community service plan."

6.2(d): Remove the term "community service plan" from this provision to comport with the revision to 4.7(f).

7.2: We recommend the removal of this provision. The federal Home and Community-Based Services regulations apply to long-term care supports and services (LTSS), not skilled home health and hospice services. With the elimination of Choices for Care from this rule, this requirement should also be eliminated. Compliance with these standards should be evaluated in the context of Choices for Care, not the revised Designation Rule.

8.2: The term "subject to state funding limits" applied to moderate needs caps so its removal is consistent with eliminating Choices for Care from the Designation Rule. The term "ability to accept referrals" does not appear in the current rule. It was something we suggested early in the process and the redline strikethrough appears to be a version control issue.

8.3 and (new) 15.3 and 15.4: We support the addition of the term "eligible" to make these sections consistent with 8.2.

8.4: The term "or the necessary funding for the service is unavailable" was a change we requested. It does not appear in the current rule and the redline strikethrough appears to be a version control issue.

15.6(a)(1): Remove the term "case manager" which was only relevant in the context of Choices for Care.

15.6(b): Based on the references in the existing rule, we believe the references should be to the new sections 15.5 (written notice) as drafted, and 15.9 (continuing care), not 15.7 which is an entirely new provision.

15.7:

1) We recommend moving this provision to follow section 15.3 so provisions regarding denials for admissions are together, which we believe will reduce confusion.

2) In the statute, the phrase "a home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated" refers to decisions about denying admissions, not just to decisions about making specific visits. That phrase should apply to both (a) and (b), not just (b) as drafted. The legislative intent is clear. This was a request that home health agencies made to the House Committee on Health Care when committee members added the phrase "mitigated or eliminated" to the bill. The purpose of the phrase was to ensure that agencies are never required to send staff to determine if a situation is still unsafe before denying the *admission,* as was happening under the law at the time.

3) The notice provision in (b)(1) adds a needless administrative burden that may discourage agencies from accepting the admission. The purpose of the language in (b) in the statute was to make it possible for agencies to accept a referral from someone previously discharged for safety by maintaining more flexibility about visits in the presence of individuals who pose a risk. The "reason" is self-evident in the provision; the agency will decline the visit if it has "reason to believe that the individual who exhibited behavior that resulted in the discharge is present in the home."

We propose the following revision:

15.7 If an individual was previously discharged from service by a home health agency in accordance with 15.4(c)(iii) or 15.4(d), and the behavior or conditions causing the discharge cannot be reasonably mitigated or eliminated, a home health agency, upon receipt of a subsequent request to admit the individual, may:

(a) deny the new admission for service; or

(b) accept the admission, but decline to send a home health agency employee to make a visit if the home health agency has reason to believe that the individual who exhibited behavior that resulted in the discharge is present in the home. **The agency will provide verbal notice to the patient if they decline a visit under this provision.**

~~(1) A home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated; however, if a home health agency employee declines to enter the home, the home health agency must provide the patient verbal notice and, within 5 business days, written notice, detailing the reasons for its decision.~~

15.8 A home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated pursuant to section 15.7.

New 15.8 becomes 15.9.

Denial/Discharge/Notice Table: The numerous provisions on denials, discharges, appeals and notice requirements are confusing to follow. We recommend including a table as an appendix to the rule that summarizes the various requirements. To support members, after the promulgation of the last version of the rule, the VNAs of Vermont created a table outlining the requirements that was approved by then DLP director Suzanne Leavitt (see attached) which could serve as the basis for the appendix.

15.9: We recommend eliminating this provision as part of the elimination of Choices for Care as a designated service, while preserving requirements to provide discharge planning. This provision appears to obligate agencies to arrange open-ended "continuing care" for individuals receiving skilled care or hospice services after they no longer meet Medicare criteria. Section 15.2 requires home health agencies to have a discharge planning process, as does CMS. The CMS provisions are below.

> **G562 (Rev. 219; Issued: 04-12-24; Effective: 04-12-24; Implementation: 04-12-24) §484.58(a) Standard: Discharge planning.**
>
> **A home health agency must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.**
>
> Interpretive Guidelines §484.58(a) The goal of discharge planning is to prepare patients and caregivers to be active partners in post-discharge care, to effectively transition the patient from HHA to post HHA care, and to reduce the factors that often lead to preventable readmissions. Data on quality and resource use measures are available on the CMS.gov web site to assist consumers in making informed decisions about the performance of HHA and other providers including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and hospices.
>
> https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf

16.3: We recommend changing "person-centered" to "individualized." Person-centered is a term more associated with Choices for Care than skilled services.

17.12: We were surprised to see this language in the draft rule. Our understanding from the stakeholder process was that the Department had agreed to eliminate this change. As we said in our e-mail comments at the time, home health agencies cannot operationalize this provision, and they already have an obligation to do something substantially similar. Home health agencies cannot provide a "clear statement about the type and amount of care to be provided" in the admission packet. The admission packet is provided PRIOR to nursing and therapy assessments. CMS allows agencies 5 days from admission to complete assessments, in part because doing so may require a combination of nurse and therapy visits that may not occur at the same time. Once the assessment is complete, patients are provided with a plan of care that describes the types of services they can expect and the approximate frequency of visits. Ultimately, the patient is getting the information suggested here, just not with the admission packet. Adding more operational specifics creates the risk of misalignment with Medicare rules, especially since this rule regulates hospice *and* home health services, but Medicare has separate Conditions of Participation for the two programs.

18.4(e): We request the elimination of this provision. Our understanding of this rule update was that it is narrow in scope, focused on eliminating Choices for Care from the rule and making technical updates based on statutory changes. Given that, home health agencies did not submit suggestions for broader revisions to the rule. This provision adds a broad new requirement open to so much interpretation it may be difficult to demonstrate compliance, within a rule that carries the risk of substantial compliance penalties.

Medicare has extensive non-discrimination and civil rights requirements that apply to all health care providers including home health agencies which were updated in 2024.

> Summary: HHS Posts Nondiscrimination in Health Programs and Activities Final Rule | CHAP
>
> Civil Rights for Providers of Health Care and Human Services | HHS.gov

21.1: The term Long Term Care Ombudsman still appears in this provision and should be removed.

22.3: This provision is causing confusion among members about whether this section refers to decisions by payers or providers. Because sections 22.1 and 22.2 apply to cases where the payer has acted, we believe this section is intended to cover cases where the home health agency has acted. We recommend the following clarification:

> 22.3 A patient or the patient representative, if applicable, who is notified by a home health agency of ~~a~~ **it's** denial of an application for admission, reduction of or discharge from services, and **who** plans to appeal ~~that~~ **the home health agency's** decision must follow the appeals process outlined in this section of the regulations.

Thank you. Please email jill@vnavt.org with any questions or to request any additional information.

Reason for Discharge	Payer	Advance Notice Timeframe	Notice Type	Continuing Care Request to DLP Available?	Appeal Organization
Homemaker funds unavailable	Medicaid	ASAP (16.3)	Verbal (16.3)	No (16.5(6))	DLP (23.3)
Not initiated by agency: Patient request, move, transfer to new provider, admission to facility/hospice	All but Medicare	ASAP (16.4(a)(i-iv))	Verbal and Written (16.4(a)(i-iv))	No (16.5(6))	N/A
Not initiated by agency: Patient request, patient move, patient transfer to new provider, admission to facility or hospice	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			
Goals met	All but Medicare	2 business days (16.4(b)(i))	Verbal and Written (16.4(b)(i))	No (16.5(6))	DLP (23.3)
Goals met	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			
Payer denial	All but Medicare	2 business days (16.4(b)(ii))	Verbal and Written (16.4(b)(ii))	No (16.5(6))	Payer (23.2)
Payer denial	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			
No physician order	All but Medicare	2 business days (16.4(b)(iii))	Verbal and Written (16.4(b)(iii))	No (16.5(6))	DLP (23.3)
No physician order	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			
Patient fails to pay share	All but Medicare	14 cal days (16.4(c)(i))	Verbal and Written (16.4(c)(i))	No (16.5(6))	DLP (23.3)
Patient fails to pay share	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			

Developed by VNAs of Vermont 1/17/2020
Approved by Suzanne Leavitt, DAIL, 1/14/20

Cannot meet patient needs	All but Medicare	14 cal days (16.4(c)(ii))	Verbal and Written (16.4(c)(ii))	Yes (16.5(6))	DLP (23.3)
Cannot meet patient needs	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			
Safety (not imminent risk)	All but Medicare	14 cal days (16.4(c)(iii))	Verbal and Written (16.4(c)(iii))	Yes (16.5(6))	DLP (23.3)
Safety (not imminent risk)	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			
Safety (imminent risk)	All but Medicare	ASAP after discharge	Verbal and Written	No (16.6(b) and 23.8)	DLP (23.3)
Safety (imminent risk)	Medicare	Follow CoP for Medicare-covered home health or hospice services. (16.8 and 23.1) Follow other payer if dual coverage for the service.			

VERMONT LEGAL AID

LONG-TERM CARE OMBUDSMAN PROGRAM
OFFICE OF THE HEALTH CARE ADVOCATE
www.vtlawhelp.org

August 15, 2025

To: Pamela Cota, Survey and Certification Director, Department of Disabilities, Aging, and Independent Living

From: Kaili Kuiper, State Long-Term Care Ombudsman and Mike Fisher, Chief Health Care Advocate

Re: 25P021 Proposed Home Health Agency Designation and Operation Rules

Ms. Cota,

Thank you for the opportunity to comment on the April 13, 2025, Proposed Home Health Agency Designation and Operations Rules. The Vermont Long-Term Care Ombudsman Program (LTCOP) represents the interests of individuals receiving long-term care including those receiving home health care through the Choices for Care program. The Office of the Health Care Advocate helps Vermonters with problems and questions related to health care services, primarily those relating to health insurance coverage enrollment, eligibility and billing. We appreciate that the LTCOP had the opportunity to comment on a previous draft and a number of our suggestions were incorporated into this draft. We have some remaining concerns that were not addressed from the old draft, and new concerns from changes in the current draft. Our most significant concern is that this new draft removes all but one reference to the LTCOP. We request the following changes be made to the proposed rules:

1) **The rule should recognize the role of the LTCOP as representatives of Vermonters receiving long-term care.** Under state law, all long-term care providers are required to ensure that "the Ombudsman and representatives of the Office have access" to long-term care clients. (33 V.S.A §7504 (b)(2)). Further, Vermont law authorizes the Long-Term care Ombudsman Program to "have appropriate access to review the medical and social records of individuals receiving long-term care" (33 V.S.A §7504 (b)(3)); and "[p]ursue administrative, judicial, or other remedies on behalf of individuals receiving long-term care. 33 V.S.A §7504(b)(4).

   Despite the LTCOP's duties and authority regarding individuals who receive long-term care, nearly all references to the Long-Term Care Ombudsman Program are

proposed to be eliminated from this rule. These rule changes remove all of the following regarding the LTCOP:

- the requirement that home health agencies must notify individuals on the Choices for Care Program of their right to contact and receive assistance from the LTCOP
- the requirement that home health agencies must provide the LTCOP's contact information to individuals when their services are being discontinued, the individual is denied admission, or the individual's complaint is not resolved.
- the statement in the rules that the LTCO has the right to access patient records, and should receive notice that a home health agency intends to discontinue its services.
- the requirement that the LTCOP must receive notice of actions for injunctive relief against a home health agency or an action for the appointment of a receiver for a home health agency.

It is not sufficient to include the Office of the Health Care Advocate (HCA) in these rules and leave out the LTCOP. Although we are under the same nonprofit, the LTCOP and the HCA have separate staff, hotlines, mandates, and areas of expertise. We also work under confidentiality requirements that limit our ability to share information freely between the two programs. It is not reasonable or feasible for the HCA to act as an intake agency for the LTCOP, be responsible for obtaining client records for the LTCOP's work, or otherwise take on direct client and general oversight work currently performed by the LTCOP for Choice for Care recipients.

We ask that the state retain all references to the LTCOP in these rules to avoid conflict with state law and confusion for providers and clients.

2) **The rule should require that whenever an HHA is required to provide a client with the LTCOP's contact information, the information should include a statement that the LTCOP helps individuals on the Choices for Care program.** This will help recipients understand whether to contact the HCA or the LTCOP.

3) **The rule should state that Home Health Agencies must provide information upon request to the LTCOP including each agency's policies and**

procedures, notices, and patient records. The LTCOP often receives questions from Vermonters that we cannot answer without additional information. It can be difficult for Vermonters to provide us with the information we need to help them. Often the home health agency will have the information but refuse to provide it to us. We need the rules to clearly state that home health agencies must cooperate with our requests for information.

4) **The rule should include standards for denial of services, or require HHAs to submit their policies regarding denials, service reductions, and discharges to DAIL for approval.** Given that these rules are making it easier for home health agencies to deny admission to applicants, there is a significant risk that HHAs will engage in discrimination against individuals with mental illness and other diagnoses the HHA believes will be challenging. DAIL should ensure that HHA policies are sufficient to reduce the opportunity for discriminatory denials. For example, a denial should be based on a clear assessment of the types of services the applicant needs and the HHA's capacity to provide those specific services. It should not be acceptable to deny an applicant based on an applicant's diagnoses.
5) **These proposed rules must incorporate monthly reporting of service denials to the state for a minimum of three years, so the state is aware of the number of people who are being denied long-term care services in Vermont.** Annual reporting is informative, but not sufficient for the state to ensure Vermonters are receiving the services they need. HHAs should submit monthly reports regarding
    - The number of applicants who were not accepted for services and the reason for the denial.
    - The number of individuals whose services were reduced or eliminated and the reason for the change.
    - The number of individuals who are receiving fewer services or hours than what their care plan calls for and why.
    - The number of individuals currently on a waiting list for services.
6) **Notices to patients must be in at least 14 point font** so long-term care recipients with vision challenges will have a better ability to read the information.
7) (2.2(u)) **The definition of medically necessary services should include services that slow the patient's decline.** We suggest amending point (2) to say, "prevent or slow deterioration or palliate the patient's condition." This would bring the rule in line with the Jimmo Settlement which clarified that Medicare

covered benefits include skilled nursing and therapy home health services needed to slow decline or deterioration.[1]

8) (12.1-12.2) **The rule should continue to require standards for unlicensed caregiver services.** If they choose to provide these services, the HHA should be required to provide the services pursuant to the patient's plan of care and ensure the competency of the caregivers they are employing.
9) (14.3) **HHAs should continue to be required to provide notice to the state, the long-term care ombudsman program, and patients if they choose to stop accepting Medicaid.** It is incredibly hard for long-term care recipients to find alternative services, especially those on Medicaid. They need as much notice as possible so they can assess their options for paying privately or finding another provider. Notice to the LTCOP will allow us to help these individuals.
10) (16.3) **The rule should not limit notice of an application denial or reduction in services to only "eligible" patients.** By only requiring home health agencies to send notices to those they have deemed eligible for services, the rule denies appeals on eligibility decisions. If applicants will not receive notice of the denial or reduction in services because they have been deemed ineligible, they cannot appeal the decision. Agencies should be required to notify individuals that they have been found to be ineligible. The notice should include information on how they can appeal the decision and contact information for the Office of the Health Care Advocate and the Vermont Long-Term Care Ombudsman Program.
11) (16.4(c)) **When a home health agency is considering discharging a patient for safety reasons, the rule should require that the HHA notify the patient what action or actions the patient must take for services to continue.** For example, a client might be told that their dangerous dog must never be present when HHA staff enter the home. This notice will allow the recipient to better understand the situation and decide whether they are willing to make the change that is required for them to be able to continue to receive services. Home health services can be vital to an individual's welfare. It is important that they know what they can do to allow services to continue.

Thank you for taking the time to consider our feedback. Please reach out if you have any questions.

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[1] See CMS.GOV, Important Message About Jimmo Settlement, https://www.cms.gov/medicare/settlements/jimmo.

VERMONT LEGAL AID

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TO: Pamela Cota, Survey and Certification Director, Department of Disabilities, Aging and Independent Living

FROM: Michael Benvenuto, Project Director, Elder Law Project; Leah Burdick, Staff Attorney, Elder Law Project

SUBJECT: 25P021 Proposed Rules for the Designation and Operation of Home Health Agencies

DATE: August 15, 2025

Vermont Legal Aid has a long history of advocacy throughout Vermont on behalf of low-income individuals, individuals with disabilities, and individuals aged 60 and older, including those on Long Term Care Medicaid Choices for Care (CFC). The Elder Law Project has serious concerns with the Department's proposed revisions to the Designation and Operation of Home Health Agencies (HHAs) Rules. We echo the comments submitted to your office by Kaili Kuiper, State Long Term Care Ombudsman and director of the Vermont Ombudsman Project. We offer these additional comments for your consideration.

1. **The Department should not remove "Unskilled Services" from the definition of "Designated Services."**

The proposed rules completely remove homemaker services/personal care/unskilled services as "Designated Services." We strongly disagree with this proposed change. We understand that due to staffing shortages, some designated home health agencies are failing to provide unskilled services to clients. While workforce challenges present barriers to providing care, we do not think removing the requirement altogether to provide such care solves the problem. The impetus for the changing of this rule seems to be primarily for the convenience of HHAs and not for the health and well-being of Vermonters.

Vermont Legal Aid anticipates those clients who have complex needs or those who are challenging to serve will no longer get any unskilled services at all, from any agency. Those with more complex medical or behavior issues, or those with challenging mental illnesses, will no longer be able to access personal care, homemaker, respite, or companionship services. Our concern is that the home health agencies will only serve the clients who are easier to serve and discriminate against those with more challenging needs. Homemaker and personal care services

allow people to stay in their homes and live with dignity. They are extremely important to patients who rely on these agencies to keep their homes habitable. Loss of these vital services and a lack of available caregivers put these vulnerable clients at higher risk for poor health outcomes, poor nutrition, possible eviction due to the state of their apartment, and potentially forced institutionalization or even homelessness.

Clients who receive both skilled and non-skilled services develop important, trusting relationships with HHA nurses and aids. HHA aids perform very personal tasks for very vulnerable people. We are concerned that the quality of care may be harder to track and supervise with undesignated agencies who are contracted to provide unskilled services. It may also result in confusing and overly complicated service plans for patients. The designation system has ensured that every eligible client has an agency that will serve them (if the client is able to follow the rules). The loss of the designation system for unskilled services will marginalize patients who are already living on the edge due to poverty, aging and disability. The Department should not remove unskilled services from the vital list of designated services HHAs are required to provide to patients.

2. **The Department should not remove all oversight for unlicensed caregivers from the proposed regulations.**

The Department proposes to remove Section XII, which requires that if an HHA provides or arranges for unlicensed caregiver services, those services must be provided under a plan of care, and the HHA must ensure the care received meets applicable standards. We do not understand why the Department removed this requirement. We also do not understand how these unlicensed services will be regulated and monitored for quality of care if the HHAs are no longer responsible for providing unskilled services or ensuring the services they contract out meet applicable standards.

3. **The Department should not remove almost all references to the Global Commitment to Health Section 1115 Demonstration Waiver Choices for Care program.**

The proposed rules remove almost all mention of the Choices for Care program. We do not understand why the Department proposed this change. These rules apply to all HHAs, including those who provide care to CFC patients. Removal of CFC language from the regulations will lead to ambiguity and confusion for patients, advocates, and HHA staff. CFC language should be clearly re-incorporated into the proposed regulations.

4. **The Department should not remove references to the State Long-Term Care Ombudsman in the proposed regulations.**

We strongly object to the Department's decision to remove practically all mention of the State Long-Term Care Ombudsman Program from the proposed regulations. The Ombudsman Program is required by law to "investigate and resolve complaints on behalf of individuals receiving long-term care." 33 V.S.A. § 7503(1). Removal of the Ombudsman Program from these regulations seems contrary to legislative intent and the explicit purpose of the Ombudsman statute. Patients receiving CFC services need to know how to contact the advocate specifically tasked by Vermont law to ensure their voices are heard.

Most problematic is the Department's decision to completely remove Sections 8.5, 13.3, 15.5, and a portion of Section 17.5 requiring HHAs to provide contact information for the State Long Term Care Ombudsman Program to CFC patients. Instead, the Department repeatedly instructs HHAs to provide contact information for the Office of the Health Care Advocate. But the Office of the Health Care Advocate does not assist patients with Long Term Care Medicaid. This proposed change will only lead to incorrect referrals and time wasted for CFC patients trying to get the help they need. Home health agencies must continue to be required to include contact information for the Long-Term Care Ombudsman Program in their notices and admission packets.

Thank you for the consideration of these comments.

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Commissioner's Office
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TO: Legislative Committee on Administrative Rules (LCAR)

FROM: Stuart G. Schurr, Esq., General Counsel SGS
Department of Disabilities, Aging & Independent Living (DAIL)

DATE: February 19, 2026

SUBJECT: 25P-021; Final Proposed Rule; *Rules for the Designation and Operation of Home Health Agencies*

The Agency of Human Services (AHS) and DAIL propose numerous amendments to the existing *Rules for the Designation and Operation of Home Health Agencies.*

A. Background

It is not uncommon for designated home health agencies, despite their best efforts to recruit and retain staff, to lack the necessary staffing to provide designated services, as currently defined, to all individuals who are referred. The severe workforce shortage of personal care attendants prevents home health agencies from complying with the requirement to serve all individuals on Choices for Care who are referred for services. As a result, most agencies are operating under a variance to this requirement. The proposed rule would remove Choices for Care services, including personal care, respite, companionship, and homemaker services, which are not "home health services," from the Rule's definition of "designated services," to ensure that agencies are not held responsible for providing services that they frequently lack staffing to provide, while allowing them to continue to provide these services when they do have sufficient staff. Without this rule change, home health agencies could be cited for noncompliance, or they could elect to discontinue the provision of a designated service in its entirety in the service area. The proposed rule makes other technical changes for clarity.

B. Specific Changes

The following chart reflects all changes made to the proposed rule since its filing with the Secretary of State:

Section of proposed Rule, as submitted to Secretary of State	Description of Change
Cover Page	Added Effective Date: "July 1, 2026"
Throughout	Restored the references to the Global Commitment to Health Section 1115 Demonstration Waiver and to the Choices for Care program, as applicable.
Throughout	Restored and added references to the Long-Term Care Ombudsman Program, as applicable.
6.2(d)	Deleted, ", including, but not limited to, development of the local community services plan"
7.2	Deleted, and renumbered subsequent subsections of Section 7, as needed.
8.2	Deleted, "state funding limits and" and, after "subject to, inserted, "ability to accept referrals.".
8.3	Restored, "or the necessary funding for the service is unavailable".
8.6(a)	Renumbered to 8.7. Struck, "to the DLP's Adult Protective Services Unit" and replaced with, "in accordance with the provisions of 33 V.S.A. § 6903 and 33 V.S.A. § 6904"
8.6(b)	Renumbered as 8.8 for clarity.
8.6	Renumbered as 8.9 for clarity and renumbered remaining sections of Section VIII.
Section XII	Restored as Section XXV
15.3	Changed "eligible" to "existing"
15.4	Changed "eligible" to "existing"
15.4(a)	Changed "eligible" to "existing"
15.4(b)	Changed "eligible" to "existing" Deleted "or" between (i) and (ii) and restored "; or" between (ii) and(iii)
15.4(c)	Changed "eligible" to "existing"
15.5(3)	Changed "XXIII." to "XXII."
15.6(b)	Changed "15.7" to "15.10".
15.7	Renumbered 15.7(b)(1) as 15.8, Inserted, "pursuant to Section 15.7" after, "mitigated or eliminated" Renumbered remaining subsections of Section 15.
17.12	Deleted, "a clear statement about the type and amount of care to be provided, and"
18.4(e)	Deleted
22.3	Struck the proposed language in its entirety and replaced it with the following: "A patient or the patient representative, if applicable, who is notified by a home health agency of its denial of an application for admission or its reduction of, or discharge from, services, and who plans to appeal the home health agency's decision must follow the appeals process outlined in this section of the rules."

C. Public Comments and DAIL's Responses

The following chart contains a summary of the public comments received and DAIL's response to those comments.

Rule	Public Comment	DAIL Response	Source
General	The Department should not remove "Unskilled Services" from the definition of "Designated Services." The proposed rules completely remove homemaker services/personal care/unskilled services as "Designated Services." We strongly disagree with this proposed change. We understand that due to staffing shortages, some designated home health agencies are failing to provide unskilled services to clients. While workforce challenges present barriers to providing care, we do not think removing the requirement altogether to provide such care solves the problem. The impetus for the changing of this rule seems to be primarily for the convenience of HHAs and not for the health and well-being of Vermonters. Vermont Legal Aid anticipates those clients who have complex needs or those who are challenging to serve will no longer get any unskilled services at all, from any agency. Those with more complex medical or behavior issues, or those with challenging mental illnesses, will no longer be able to access personal care, homemaker, respite, or companionship services. Our concern is that the home health agencies will only serve the clients who are easier to serve and discriminate against those with more challenging needs. Homemaker and personal care services allow people to stay in their homes and live with dignity. They are extremely important to patients who rely on these agencies to keep their homes habitable. Loss of these vital services and a lack of available caregivers put these vulnerable clients at higher risk for poor health outcomes, poor nutrition, possible eviction due to the state of their apartment, and potentially forced institutionalization or even homelessness. Clients who receive both skilled and non-skilled services develop important, trusting relationships with HHA nurses and aids. HHA aids perform very personal tasks for very vulnerable people. We are concerned that the quality of care may be harder to track and	The Department declines to make the requested change. Despite the removal of unskilled services from the definition of "designated services," the proposed rule does not prohibit any home health agency from providing those unskilled services. It is important to recognize, however, that unskilled services are not home health services, and many agencies lack the capacity to provide both home health services and	Vermont Legal Aid (Michael Benvenu to & Leah Burdick)

	supervise with undesignated agencies who are contracted to provide unskilled services. It may also result in confusing and overly complicated service plans for patients. The designation system has ensured that every eligible client has an agency that will serve them (if the client is able to follow the rules). The loss of the designation system for unskilled services will marginalize patients who are already living on the edge due to poverty, aging and disability. The Department should not remove unskilled services from the vital list of designated services HHAs are required to provide to patients.	unskilled services. Absent the removal of the unskilled Choices for Care services from the definition of designated services, or the continued issuance of variances, home health agencies could inform the Department that it is no longer providing any CFC services altogether in order to remain in compliance with the Rules. The Department believes that many home health agencies will continue to provide unskilled services, even if their provision is not required Further, the Department has identified multiple providers of	

		these services, all of which have been enrolled as Vermont Medicaid providers, and is working to identify and enroll additional providers to deliver these unskilled services.	
General	The Department should not remove all oversight for unlicensed caregivers from the proposed regulations. The Department proposes to remove Section XII, which requires that if an HHA provides or arranges for unlicensed caregiver services, those services must be provided under a plan of care, and the HHA must ensure the care received meets applicable standards. We do not understand why the Department removed this requirement. We also do not understand how these unlicensed services will be regulated and monitored for quality of care if the HHAs are no longer responsible for providing unskilled services or ensuring the services they contract out meet applicable standards.	The Department agrees to restore this requirement (see new Section XXV).	Vermont Legal Aid (Michael Benvenu to & Leah Burdick)
General	The Department should not remove almost all references to the Global Commitment to Health Section 1115 Demonstration Waiver Choices for Care program. The proposed rules remove almost all mention of the Choices for Care program. We do not understand why the Department proposed this change. These rules apply to all HHAs, including those who provide care to CFC patients. Removal of CFC language from the regulations will lead to ambiguity and confusion for patients, advocates, and HHA staff. CFC language should be clearly re-incorporated into the proposed regulations.	The Department agrees to restore the references to the Global Commitment to Health Section 1115 Demonstratio n Waiver and to the Choices for Care program, as applicable.	Vermont Legal Aid (Michael Benvenu to & Leah Burdick)

General	The Department should not remove references to the State Long-Term Care Ombudsman in the proposed regulations. We strongly object to the Department's decision to remove practically all mention of the State Long-Term Care Ombudsman Program from the proposed regulations. The Ombudsman Program is required by law to "investigate and resolve complaints on behalf of individuals receiving long-term care." 33 V.S.A. § 7503(1). Removal of the Ombudsman Program from these regulations seems contrary to legislative intent and the explicit purpose of the Ombudsman statute. Patients receiving CFC services need to know how to contact the advocate specifically tasked by Vermont law to ensure their voices are heard. Most problematic is the Department's decision to completely remove Sections 8.5, 13.3, 15.5, and a portion of Section 17.12 requiring HHAs to provide contact information for the State Long Term Care Ombudsman Program to CFC patients. Instead, the Department repeatedly instructs HHAs to provide contact information for the Office of the Health Care Advocate. But the Office of the Health Care Advocate does not assist patients with Long Term Care Medicaid. This proposed change will only lead to incorrect referrals and time wasted for CFC patients trying to get the help they need. Home health agencies must continue to be required to include contact information for the Long-Term Care Ombudsman Program in their notices and admission packets.	The Department agrees to restore the references to the Long-Term Care Ombudsman Program, as applicable.	Vermont Legal Aid (Michael Benvenu to & Leah Burdick)
General	The rule should recognize the role of the LTCOP as representatives of Vermonters receiving long-term care. Under state law, all long-term care providers are required to ensure that "the Ombudsman and representatives of the Office have access" to long-term care clients. (33 V.S.A §7504 (b)(2)). Further, Vermont law authorizes the Long-Term care Ombudsman Program to "have appropriate access to review the medical and social records of individuals receiving long-term care" (33 V.S.A §7504 (b)(3)); and "[p]ursue administrative, judicial, or other remedies on behalf of individuals receiving long-term care. 33 V.S.A §7504(b)(4). Despite the LTCOP's duties and authority regarding individuals who receive long-term care, nearly all references to the Long-Term Care Ombudsman	The Department agrees to restore the references to the Long-Term Care Ombudsman Program, as applicable.	Kaili Kuiper, SLTCO

	Program are proposed to be eliminated from this rule. These rule changes remove all of the following regarding the LTCOP: • the requirement that home health agencies must notify individuals on the Choices for Care Program of their right to contact and receive assistance from the LTCOP • the requirement that home health agencies must provide the LTCOP's contact information to individuals when their services are being discontinued, the individual is denied admission, or the individual's complaint is not resolved. • the statement in the rules that the LTCO has the right to access patient records, and should receive notice that a home health agency intends to discontinue its services. • the requirement that the LTCOP must receive notice of actions for injunctive relief against a home health agency or an action for the appointment of a receiver for a home health agency. It is not sufficient to include the Office of the Health Care Advocate (HCA) in these rules and leave out the LTCOP. Although we are under the same nonprofit, the LTCOP and the HCA have separate staff, hotlines, mandates, and areas of expertise. We also work under confidentiality requirements that limit our ability to share information freely between the two programs. It is not reasonable or feasible for the HCA to act as an intake agency for the LTCOP, be responsible for obtaining client records for the LTCOP's work, or otherwise take on direct client and general oversight work currently performed by the LTCOP for Choice for Care recipients. We ask that the state retain all references to the LTCOP in these rules to avoid conflict with state law and confusion for providers and clients.		
General	The rule should require that whenever an HHA is required to provide a client with the LTCOP's contact information, the information should include a statement that the LTCOP helps individuals on the Choices for Care program. This will help recipients understand whether to contact the HCA or the LTCOP.	The Department declines to expand this requirement beyond what is already contained in the rules. (See	Kaili Kuiper, SLTCO

		Sections 8.5, 13.3(b), 15.5, 15.6(c), 15.9(c), and 21.5)	
General	The rule should state that Home Health Agencies must provide information upon request to the LTCOP including each agency's policies and procedures, notices, and patient records. The LTCOP often receives questions from Vermonters that we cannot answer without additional information. It can be difficult for Vermonters to provide us with the information we need to help them. Often the home health agency will have the information but refuse to provide it to us. We need the rules to clearly state that home health agencies must cooperate with our requests for information.	The Department declines to add the requested language. 33 V.S.A. § 7504(b)(3) currently authorizes the Office of the LTCO to "[h]ave appropriate access to review the medical and social records of an individual receiving long-term care as required by 42 U.S.C. § 3058g(b), as the Health Insurance Portability and Accountabilit y Act of 1996 Privacy Rule, 45 C.F.R. Part 160 and 45 C.F.R. Part 164, subparts A and E, does not preclude release by	Kaili Kuiper, SLTCO

		covered entities of residents' private health information or other resident-identifying information to the Ombudsman program, including residents' medical, social, or other records; a list of resident names and room numbers; or information collected in the course of a State or federal survey or inspection process. If a provider fails to comply with a request for such information, the LTCOP, not the licensing agency, is best suited and equipped to pursue the appropriate remedy.	
General	The rule should include standards for denial of services, or require HHAs to submit their policies regarding denials, service reductions, and discharges to	The Department declines to	Kaili Kuiper, SLTCO

	DAIL for approval. Given that these rules are making it easier for home health agencies to deny admission to applicants, there is a significant risk that HHAs will engage in discrimination against individuals with mental illness and other diagnoses the HHA believes will be challenging. DAIL should ensure that HHA policies are sufficient to reduce the opportunity for discriminatory denials. For example, a denial should be based on a clear assessment of the types of services the applicant needs and the HHA's capacity to provide those specific services. It should not be acceptable to deny an applicant based on an applicant's diagnoses.	make the requested change. The standards in Sections 15.4(a), (b), and (c) apply to reductions in, and discharges from, services. Further, discriminatio n is unlawful. As per Section 19.2, the Department will monitor home health agencies for continued compliance with applicable laws and rules at least annually and may conduct more frequent surveys in response to complaints. Noncomplian ce will result in enforcement action, which may include, but not be limited to, daily financial penalties, license	

		suspension or revocation, or the suspension of admissions.	
General	These proposed rules must incorporate monthly reporting of service denials to the state for a minimum of three years, so the state is aware of the number of people who are being denied long-term care services in Vermont. Annual reporting is informative, but not sufficient for the state to ensure Vermonters are receiving the services they need. HHAs should submit monthly reports regarding the number of applicants who were not accepted for services and the reason for the denial. The number of individuals whose services were reduced or eliminated and the reason for the change. The number of individuals who are receiving fewer services or hours than what their care plan calls for and why. The number of individuals currently on a waiting list for services.	The Department declines to incorporate the requested language.	Kaili Kuiper, SLTCO
General	Notices to patients must be in at least 14-point font so long-term care recipients with vision challenges will have a better ability to read the information.	As per Section 7.2, all home health agencies must comply with the Americans with Disabilities Act. As such an additional requirement could result in an economic impact on the agencies, the Department declines to add this requirement	Kaili Kuiper, SLTCO

		to these Rules. It is the Department's hope and expectation, however, that agencies' notices are accessible to their patients, including, but not limited to, those with visual impairments.	
12.1-12.2	The rule should continue to require standards for unlicensed caregiver services. If they choose to provide these services, the HHA should be required to provide the services pursuant to the patient's plan of care and ensure the competency of the caregivers they are employing.	DAIL agrees to restore this requirement (see new Section XXV).	Kaili Kuiper, SLTCO
14.3	HHAs should continue to be required to provide notice to the state, the long-term care ombudsman program, and patients if they choose to stop accepting Medicaid. It is incredibly hard for long-term care recipients to find alternative services, especially those on Medicaid. They need as much notice as possible so they can assess their options for paying privately or finding another provider. Notice to the LTCOP will allow us to help these individuals.	The commenter is referring to the proposed Section 13.3. The Department agrees to restore this requirement.	Kaili Kuiper, SLTCO
16.3	The rule should not limit notice of an application denial or reduction in services to only "eligible" patients. By only requiring home health agencies to send notices to those they have deemed eligible for services, the rule denies appeals on eligibility decisions. If applicants will not receive notice of the denial or reduction in services because they have been deemed ineligible, they cannot appeal the decision. Agencies should be required to notify individuals that they have been found to be ineligible. The notice should include information on how they can appeal the decision and contact information for the Office of the	The commenter is referring to the proposed Section 15.3. The Department agrees to replace "eligible"	Kaili Kuiper, SLTCO

	Health Care Advocate and the Vermont Long-Term Care Ombudsman Program.	with "existing" in Sections 15.3 and 15.4, as appropriate.	
16.4(c)	When a home health agency is considering discharging a patient for safety reasons, the rule should require that the HHA notify the patient what action or actions the patient must take for services to continue. For example, a client might be told that their dangerous dog must never be present when HHA staff enter the home. This notice will allow the recipient to better understand the situation and decide whether they are willing to make the change that is required for them to be able to continue to receive services. Home health services can be vital to an individual's welfare. It is important that they know what they can do to allow services to continue.	The commenter is referring to the proposed Section 15.4(c). The Department declines to add this requirement. Notices must already list the reason (see Section 15.5). The client may work with the agency to try to identify a remedy. Currently, notices also inform the client of the right to appeal.	Kaili Kuiper, SLTCO
4.7(f)	We support this change which comports with the law that eliminated the "community service plan."	N/A	Jill Mazza Olson, VNAs of Vermont
6.2(d)	Remove the term "community service plan" from this provision to comport with the revision to 4.7(f).	The Department agrees to make these changes to the rule at 6.2(d).	Jill Mazza Olson, VNAs of Vermont

7.2	We recommend the removal of this provision. The federal Home and Community-Based Services regulations apply to long-term care supports and services (LTSS), not skilled home health and hospice services. With the elimination of Choices for Care from this rule, this requirement should also be eliminated. Compliance with these standards should be evaluated in the context of Choices for Care, not the revised Designation Rule.	The Department agrees to delete this provision and re-number the remaining subsections.	Jill Mazza Olson, VNAs of Vermont
8.2	The term "subject to state funding limits" applied to moderate needs caps so its removal is consistent with eliminating Choices for Care from the Designation Rule. The term "ability to accept referrals" does not appear in the current rule. It was something we suggested early in the process and the redline strikethrough appears to be a version control issue.	The Department agrees to delete "state funding limits" and, after "subject to," insert, "ability to accept referrals".	Jill Mazza Olson, VNAs of Vermont
8.3 (& 15.3 & 15.4)	We support the addition of the term "eligible" to make these sections consistent with 8.2.	The Department agrees to retain the term "eligible" in Section 8.3 but will change "eligible" to "existing" in Sections 15.3 and 15.4.	Jill Mazza Olson, VNAs of Vermont
8.4	The term "or the necessary funding for the service is unavailable" was a change we requested. It does not appear in the current rule and the redline strikethrough appears to be a version control issue.	The commenter is referring to Section 8.3. The existing rule includes "or the necessary funding for the service is unavailable." The	Jill Mazza Olson, VNAs of Vermont

		Department inadvertently struck this language and will restore it.	
15.6(a)(1)	Remove the term "case manager" which was only relevant in the context of Choices for Care.	The Department declines to strike this language. If a home health agency elects to provide Choices for Care services and is providing those services to a patient it is planning to discharge for safety reasons, the home health agency must notify the patient's case manager.	Jill Mazza Olson, VNAs of Vermont
15.6(b)	Based on the references in the existing rule, we believe the references should be to the new sections 15.5 (written notice) as drafted, and 15.9 (continuing care), not 15.7, which is an entirely new provision.	DAIL agrees to change "15.7" to "15.10".	Jill Mazza Olson, VNAs of Vermont
15.7	1) We recommend moving this provision to follow section 15.3 so provisions regarding denials for admissions are together, which we believe will reduce confusion. 2) In the statute, the phrase "a home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated" refers to decisions about denying admissions, not just to decisions about making specific visits. That phrase should apply to both (a) and (b), not just (b) as drafted. The legislative intent is clear. This was a request that home health	1) The Department declines to move Section 15.7, as citations will direct providers to the correct section. 2) The Department	Jill Mazza Olson, VNAs of Vermont

	agencies made to the House Committee on Health Care when committee members added the phrase "mitigated or eliminated" to the bill. The purpose of the phrase was to ensure that agencies are never required to send staff to determine if a situation is still unsafe before denying the *admission,* as was happening under the law at the time. 3) The notice provision in (b)(1) adds a needless administrative burden that may discourage agencies from accepting the admission. The purpose of the language in (b) in the statute was to make it possible for agencies to accept a referral from someone previously discharged for safety by maintaining more flexibility about visits in the presence of individuals who pose a risk. The "reason" is self-evident in the provision; the agency will decline the visit if it has "reason to believe that the individual who exhibited behavior that resulted in the discharge is present in the home." We propose the following revision: 15.7 If an individual was previously discharged from service by a home health agency in accordance with 15.4(c)(iii) or 15.4(d), and the behavior or conditions causing the discharge cannot be reasonably mitigated or eliminated, a home health agency, upon receipt of a subsequent request to admit the individual, may: (a) deny the new admission for service; or (b) accept the admission, but decline to send a home health agency employee to make a visit if the home health agency has reason to believe that the individual who exhibited behavior that resulted in the discharge is present in the home. The agency will provide verbal notice to the patient if they decline a visit under this provision. (1) A home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated; however, if a home health agency employee declines to enter the home, the home health agency must provide the patient verbal notice and, within 5 business days, written notice, detailing the reasons for its decision.	agrees to change 15.7(b)(1) to 15.8 and to renumber the remaining sections. 3) The Department declines to edit the requirement, as written notice is necessary for clear and effective communicati on.	
15.8	A home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated pursuant to section 15.7. New 15.8 becomes 15.9.	The Department agrees to add, "pursuant to	Jill Mazza Olson,

	Denial/Discharge/Notice Table: The numerous provisions on denials, discharges, appeals and notice requirements are confusing to follow. We recommend including a table as an appendix to the rule that summarizes the various requirements. To support members, after the promulgation of the last version of the rule, the VNAs of Vermont created a table outlining the requirements that was approved by then DLP director Suzanne Leavitt (see attached) which could serve as the basis for the appendix.	Section 15.7." to the new Section 15.8. The Department believes it is unnecessary to create a table at this time.	VNAs of Vermont
15.9	We recommend eliminating this provision as part of the elimination of Choices for Care as a designated service, while preserving requirements to provide discharge planning. This provision appears to obligate agencies to arrange open-ended "continuing care" for individuals receiving skilled care or hospice services after they no longer meet Medicare criteria. Section 15.2 requires home health agencies to have a discharge planning process, as does CMS. The CMS provisions are below. G562 (Rev. 219; Issued: 04-12-24; Effective: 04-12-24; Implementation: 04-12-24) §484.58(a) Standard: Discharge planning. A home health agency must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. Interpretive Guidelines §484.58(a) The goal of discharge planning is to prepare patients and caregivers to be active partners in post-discharge care, to effectively transition the patient from HHA to post HHA care, and to reduce the factors that often lead to preventable readmissions. Data on quality and resource use measures are available on the CMS.gov web site to assist consumers in making informed decisions about the performance of HHA and other providers including	The Department declines to eliminate this provision, as it is not specific to Choices for Care and offers protection of discharged clients.	Jill Mazza Olson, VNAs of Vermont

	skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and hospices. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf		
16.3	We recommend changing "person-centered" to "individualized." Person-centered is a term more associated with Choices for Care than skilled services.	The Department declines to change the language, as the term "person-centered" is widely used in connection with skilled services.	Jill Mazza Olson, VNAs of Vermont
17.12	We were surprised to see this language in the draft rule. Our understanding from the stakeholder process was that the Department had agreed to eliminate this change. As we said in our e-mail comments at the time, home health agencies cannot operationalize this provision, and they already have an obligation to do something substantially similar. Home health agencies cannot provide a "clear statement about the type and amount of care to be provided" in the admission packet. The admission packet is provided PRIOR to nursing and therapy assessments. CMS allows agencies 5 days from admission to complete assessments, in part because doing so may require a combination of nurse and therapy visits that may not occur at the same time. Once the assessment is complete, patients are provided with a plan of care that describes the types of services they can expect and the approximate frequency of visits. Ultimately, the patient is getting the information suggested here, just not with the admission packet. Adding more operational specifics creates the risk of misalignment with Medicare rules, especially since this rule regulates hospice *and* home health services, but Medicare has separate Conditions of Participation for the two programs.	The Department agrees to strike the language in question, as it was intended to be removed prior to the submission of the proposed rule.	Jill Mazza Olson, VNAs of Vermont
18.4(e)	We request the elimination of this provision. Our understanding of this rule update was that it is narrow in scope, focused on eliminating Choices for Care from	The Department agrees to	Jill Mazza Olson,

	the rule and making technical updates based on statutory changes. Given that, home health agencies did not submit suggestions for broader revisions to the rule. This provision adds a broad new requirement open to so much interpretation it may be difficult to demonstrate compliance, within a rule that carries the risk of substantial compliance penalties. Medicare has extensive non-discrimination and civil rights requirements that apply to all health care providers including home health agencies which were updated in 2024. Summary: HHS Posts Nondiscrimination in Health Programs and Activities Final Rule | CHAP Civil Rights for Providers of Health Care and Human Services | HHS.gov	eliminate 18.4(e).	VNAs of Vermont
21.1	The term Long Term Care Ombudsman still appears in this provision and should be removed.	The Department envisions circumstances where a representative of the LTCOP may have reason to submit a complaint on behalf of an individual served by a home health agency. As such, the Department declines to delete this provision.	Jill Mazza Olson, VNAs of Vermont
22.3	22.3: This provision is causing confusion among members about whether this section refers to decisions by payers or providers. Because sections 22.1 and 22.2 apply to cases where the payer has acted, we believe this section is intended to cover cases where the home health agency has acted. We recommend the following clarification: 22.3 A patient or the patient representative, if applicable, who is notified by a home health agency of	The Department agrees to clarify this provision.	Jill Mazza Olson, VNAs of Vermont

	~~a~~ it's [sic] denial of an application for admission, reduction of or discharge from services, and who plans to appeal that the home health agency's decision must follow the appeals process outlined in this section of the regulations.		

Annotated Text

~~REGULATIONS~~

RULES FOR

THE

DESIGNATION AND OPERATION

OF

HOME HEALTH AGENCIES

Agency of Human Services
Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive
Waterbury, VT 05671-2020

Effective Date: ~~October 1, 2019~~July 1, 2026

This material is available upon request in alternative formats.

Table of Contents

Section

I. General Provisions

1.1 Purpose. It is the purpose of these rules to implement the laws of the State of Vermont ("State") governing the designation, re-designation, and designation revocation of home health agencies, and the minimum program standards for home health agencies.

1.2 Policy. It is the policy of the State to ensure that, subject to available funding from the State, all Vermont residents within the State have access to comprehensive, medically necessary, high quality home health services without regard to the patient's ability to pay. It is further the policy of the State to ensure that such services are delivered in an efficient and cost-effective manner, under a regulatory framework designed to control costs while not compromising quality or duplicating services.

1.3 Statutory Authority. These rules are adopted pursuant to 33 V.S.A. § 6303(a).

1.4 Statement of Intent. Upon the effective date of these ~~regulations~~rules, all home health agencies in Vermont ~~shall be required to~~must adhere to the ~~regulations~~ rules as adopted. Any designated service provided under an approved separate entity is also subject to these ~~regulations~~rules. Services which are not subject to designation include wellness and prevention services, clinics, and private duty services.

1.5 Exception and Severability. If any provision of these ~~regulations~~rules, or the application of any provision of these ~~regulations~~rules, is determined to be invalid, the determination of invalidity will not affect any other provision of these ~~regulations~~rules or the application of any other provision of these ~~regulations~~rules.

1.6 Taxes. All home health agencies in Vermont ~~shall~~must be in good standing with the Vermont Department of Taxes, pursuant to 32 V.S.A. §3113. Failure to do so ~~shall~~will result in the denial or revocation of designation as a home health agency.

1.7 Material Misstatements. A material misstatement related to designation, re-designation or the law governing home health agencies in Vermont made to the State Survey Agency by a home health agency during the designation or re-designation process, or at any time during which the home health agency is an agency in Vermont, may result in the denial of designation or re-designation, designation revocation or other enforcement action.

1.8 Fair Hearing. A person or entity aggrieved by a decision of the Division of Licensing and Protection's State Survey Agency may file a request for a fair hearing with the Human Services Board as provided in 3 V.S.A. §3091.

II. Definitions.

2.1 General Definitions. For purposes of these ~~regulations~~rules, words and phrases are given their ordinary meanings unless otherwise specifically defined herein.

2.2 Specific Definitions. The words and phrases below, as used in these ~~regulations~~rules, have the following meanings, unless otherwise indicated:

(a) *Activities of Daily Living* means routine activities related to self-care, including, but not limited to, dressing and undressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility in and around the home and eating.

(b) *Administrator* means an individual, who may also be the supervising physician or registered nurse, who organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff; employs qualified personnel and ensures adequate staff education and evaluations; ensures the accuracy of public information materials and activities; and implements an effective budgeting and accounting system. A qualified person is authorized in writing to act in the absence of the administrator.

(c) *Applicant* means the individual who signs the application for a home health agency designation.

(d) *Applicant for services* means an individual residing in a designated service area requesting services or care from a home health agency.

(e) *Branch Office* means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to the parent agency so that it shares administration, supervision, and services with the parent agency on a daily basis. The branch office is not required to independently meet the Conditions of Participation as a home health agency.

(f) *Clinician orders for life-sustaining treatment* or *COLST* means a clinician's order or orders for treatment, such as intubation, mechanical ventilation, transfer to hospital, antibiotics, artificially administered

nutrition, or other medical intervention. A COLST order is designed for use in outpatient settings and health care facilities and may include a DNR order that meets the requirements of 18 V.S.A. § 9708.

(g) *Commissioner* means the Commissioner of ~~the Department of~~ Disabilities, Aging, and Independent Living.

(h) *Complaint* means a concern raised by a patient, a patient's family member or a patient representative, regarding treatment or care that is (or that fails to be) furnished, or regarding the lack of respect for the patient or the patient's property, by the agency or by anyone furnishing services on behalf of the home health agency.

(i) *Conditional designation* means a designation upon which certain requirements for operation have been imposed by the Department of Disabilities, Aging, and Independent Living.

(j) *Critical Incident* means an unexpected occurrence, related to the provision of home health services, involving death, patient suicide, poisoning, and/or serious physical or psychological injury that requires medical treatment or hospitalization. Such incidents may include, but are not limited to, equipment failure, medication error, the misuse of medical devices or restraints or suspected abuse, neglect or exploitation.

(k) *Department* means the Department of Disabilities, Aging, and Independent Living.

(l) *Designated Services* means:

1. Medically necessary, intermittent, skilled home health services provided by Medicare-certified home health agencies of the type covered under Title XVIII (Medicare) or XIX (Medicaid) of the Social Security Act;
2. Hospice services of the type covered under Title XVIII (Medicare) or XIX (Medicaid) of the Social Security Act; and
~~3. Personal care, respite care, companion care and homemaker services provided under the Choices for Care program and authorized within the State's mandated funding limits.~~
~~4~~3. The term "designated services" ~~shall~~does not include any other service provided by a home health agency.

(m) *Designation* (for a home health agency) means that the agency has been approved by the Department to provide skilled home health services and hospice services in the state of Vermont.

(~~m~~n) *Discharge* means the termination of the services provided to a patient by the home health agency.

(~~n~~o) *Eligible* means the individual meets the clinical and financial criteria for the applicable service or program and the requested care and services are appropriate to be delivered in the home environment.

(~~o~~p) *Family member* means an individual who is related to a person by blood, marriage, civil union, or adoption, or who considers himself or herself to be family based upon bonds of affection, and who currently shares a household with such a person or has, in the past, shared a household with that person. For purposes of this definition, the phrase "bonds of affection" means enduring ties that do not depend on the existence of an economic relationship.

(~~p~~q) *For-profit home health agency* means a private home health agency that is not exempt from Federal income tax under Section 501 of the Internal Revenue Code.

(~~q~~r) *Home health agency* means a for-profit or nonprofit home health care business, certified by the Centers for Medicare and Medicaid Services to participate in Medicare and Medicaid, which provides part-time or intermittent skilled nursing services and at least one of the following other therapeutic services, made available on a visiting basis, in a place of residence used as a patient's home: physical, speech, or occupational therapy; medical social services; home health aide services; or other non-nursing therapeutic services, including, but not limited to, the services of nutritionists, dieticians, psychologists, and licensed mental health counselors.

(~~r~~s) *Home health services* means the activities and functions of a home health agency that include, but are not limited to, nursing care, ~~personal care,~~ physical, occupational or speech therapy, medical social services, or other non-nursing therapeutic services directly related to care, treatment, or diagnosis of patients in the home.

(~~s~~t) *Homemaker Services* means certain activities that help maintain a safe, healthy environment for persons residing in their homes. These activities include home management services (cooking, cleaning, laundry and related light housework) and supportive services (shopping and errands) essential to maintain the living quarters. Homemaker services may be provided by a home health agency but are not a designated service.

(~~t~~u) *Instrumental Activities of Daily Living ("IADLs")* means activities that are not necessary for basic functioning but are necessary to live independently. These activities may include, but are not limited to, light housework, preparing and cleaning up after meals, shopping and mobility in the community.

(~~u~~v) *Medically Necessary Services* means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the patient's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

(1) help restore or maintain the patient's health; or

(2) prevent deterioration or palliate the patient's condition; or

(3) prevent the reasonably likely onset of a health problem or detect an incipient problem.

(~~v~~w) *Medicare Conditions of Participation* (CoP) means federal regulations with which particular health care facilities must comply in order to participate in the Medicare and Medicaid programs.

(~~w~~x) *Nonprofit home health agency* means a home health agency exempt from Federal income tax under Section 501 of the Internal Revenue Code.

(y) *Nursing care* means direct and indirect care provided by a registered nurse, licensed practical nurse, or nursing assistant.

(~~x~~z) *"Patient record" or "Patient records"* mean documents in the custody of the home health agency, written or electronic, that pertain to the care and services provided to patients by a home health agency, whether authored by the home health agency or not.

(aa~~y~~) *Patient representative* means an individual who is authorized by the patient to communicate with the home health agency on behalf of the patient. A patient representative includes, but is not limited to, an attorney, a representative payee, a guardian, or an agent under a power of attorney or advance directive. Depending on the authority granted by the patient or under state or federal law, a patient representative may support the patient with decision-making, accessing information and conveying concerns for the patient including, but not limited to, grievances, complaints, and appeals, and ~~to~~ receiv~~e~~ing information from the home health agency on behalf of the patient regarding these matters.

(bb~~z~~) *Personal Care* means providing or assisting an individual with the Activities of Daily Living that the individual otherwise would be unable to complete. Personal Care services may be provided by a home health agency but are not designated services.

(ccaa) *Plan of care* means a written description of the steps that will be taken to meet personal, psychosocial, social, nursing, rehabilitative and/or medical needs of the patient.

(ddbb) *Plan of correction* means the home health agency's response to the statement of deficiencies issued by the State Survey Agency that describes the steps the agency will take to achieve regulatory compliance.

(eecc) *Poisoning* means the ingestion of any toxic substance that impairs health or destroys life when ingested, inhaled or absorbed in a relatively small amount.

(ffdd) *Provisional designation* means a temporary designation approval from the Department of Disabilities, Aging and Independent Living for not more than one year for a home health agency seeking initial Medicare certification.

(ggee) *Shared Services Agreement* means cooperative arrangements between or among two or more home health agencies, which are approved by the Commissioner or the Commissioner's designee, to pool or share one or more home health services, including, but not limited to, skilled services, for the purpose of addressing the special needs or exceptional circumstances of patients located in one or more of their designated services areas or obtaining cost savings and efficiencies for the benefit of patients.

(hhff) *Skilled services* means medically necessary services that require the skills of a qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists and speech-language pathologists. Skilled services ~~shall~~must meet the Medicare Conditions of Participation and must be provided directly by, or under the general supervision of, these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

(ii) *Unskilled services* means services that are non-medical and do not require professional licensure or a medical provider's orders. These services include, but are not limited to, personal care, homemaker, respite, and companionship services. Unskilled services are not designated services.

(jigg) *Variance* means a written determination from the State Survey Agency, based upon the written request of a licensee, which, temporarily and in limited, defined circumstances, waives compliance with a specific regulation.

III. Variances

3.1 Variances from these ~~regulations~~rules may be granted upon a determination by the State Survey Agency, the Commissioner, or Commissioner's designee. It is incumbent upon the home health agency to demonstrate that:

(a) strict compliance would impose a substantial hardship on the home health agency or the patient; and

(b) any hardship alleged to result from imposition of a ~~regulation~~rule from which a variance is sought was not created by the home health agency; and

(c) the home health agency will otherwise meet the goal or satisfy the intent of the ~~regulation~~rule that is the subject of the variance request and the relevant statutory provision.; and

(d) a variance will not result in decreased services to the patients served by the agency, nor will it result in a decrease in the protection of the health, safety or welfare of the patients served by the agency; and

(e) a variance will not conflict with other legal requirements.

3.2 Requests for a variance ~~shall~~must be submitted to the State Survey Agency in writing. The request ~~shall~~must include:

(a) the citation for the ~~regulation~~rule that is the subject of the variance request; and

(b) the reason(s) why the variance is being requested, and

(c) a description of the alternative method proposed for meeting the intent of the ~~regulation~~rule that is the subject of the variance request.

3.3 A variance ~~shall~~will not be granted from a ~~regulation~~rule pertaining to patient rights.

3.4 Variances are subject to review and termination by the State Survey Agency at any time.

IV. The Designation Process

4.1 Any person, partnership, association or corporation, including a home health agency established outside of Vermont, seeking to become a home

health agency in Vermont ~~shall~~must apply for and obtain a Certificate of Need ("CON") from the Green Mountain Care Board ("GMCB") prior to filing an application for designation with the Department.

4.2 Any person, partnership, association or corporation, including a home health agency established outside of Vermont, seeking to become a home health agency in Vermont ~~shall~~ must, in addition to obtaining a CON from the GMCB, obtain and maintain federal certification as a home health agency by the Centers for Medicare and Medicaid Services ("CMS") prior to filing an application for designation with the Department. If nationally accredited and deemed, the home health agency ~~shall~~ must provide the Department with documentation of that status and notify the Department of any change in status and the reason for the change in status.

4.3 Any person, partnership, association or corporation, including a home health agency established outside of Vermont, seeking to become a home health agency in Vermont, ~~shall~~must, after obtaining a CON from the GMCB, file an application for designation with, and obtain approval from, the Department prior to the commencement of such operation.

4.4 Applications to become a home health agency in Vermont ~~shall~~ must be submitted upon forms approved by the Department.

4.5 A home health agency's application for designation ~~shall~~ must include:

(a) The legal name of the home health agency, as registered with the Secretary of State's Office; the name under which it ~~shall~~ will be doing business; its physical address; and, if applicable, the name of the corporation, association or other company responsible for the management of the home health agency;

(b) A completed disclosure of ownership form (obtained from the Department);

(c) A list of all board members, officers, partners, and key administrative staff and their titles, including the names of the administrator and the director of nursing or equivalent, with copies of current licenses;

(d) Proof of CON for the geographic service area where designation is sought;

(e) Proof of Medicare home health agency certification;

(f) The number of full-time equivalent employees by discipline;

(g) An organizational chart showing all reporting and supervisory relationships;

(h) Other information, data, statistics or schedules as the Department may request, including, but not limited to, information on accounts, salaries, tax status and evidence of financial solvency;

(i) The name of each person, firm or corporation having direct or indirect ownership interest of 5% or more in the home health agency, specifying the amount, and the name of each physician with financial interest or ownership of any amount in the home health agency, specifying the amount;

~~(j) A local community services plan;~~

(~~k~~j) A list of specific services provided by the home health agency, and a list of those services the home health agency arranges for the provision of by contract; and

(~~l~~k) A sample home health services admission packet.

4.6 When an applicant is a corporation, the application ~~shall~~ must be signed by two (2) officers of the corporation and by the corporation's Chief Executive Officer or Executive Director, all of whom ~~shall~~ must have the authority to legally bind the corporation.

4.7 The Department ~~shall~~ will consider each of the following factors in determining whether a home health agency's application or re-application ~~shall~~ will be approved for designation or re-designation, as applicable:

(a) CON determination;

(b) Record of compliance with, or violation of, any relevant regulations and laws;

(c) Adherence to accepted professional standards and principles in the provision of services;

(d) Financial status and proof of fiscal responsibility, as shown through:

(1) an annual audit report, which includes an unqualified opinion from an independent auditor and indicates that a home health agency is in compliance with generally accepted accounting standards and that the financial reports are an accurate representation of the agency's financial condition;

(2) credit reports;

(3) history of tax withholding;

(4) history of financial fraud with any third-party payer or vendor;

(5) history of inappropriate referral arrangements; and

(6) compliance with the financial terms and conditions of all state contracts;

(e) Current standing with state and federal tax departments; and

(f) ~~Development and implementation of an approved local community service plan.~~ Engagement in planning and needs assessments, as directed by State and federal law, which may include participating in the development of the Health Resource Allocation Plan published pursuant to 18 V.S.A. § 9405 and the community health needs assessment conducted in accordance with 26 U.S.C. § 501(r)(3).

4.8 A home health agency designated to provide ~~home health~~ services in Vermont ~~shall have~~has the obligation and the responsibility to provide or arrange for the provision of all designated services to all eligible patients within its designated geographic area who request services~~, subject to state funding limits and ability to accept referrals~~.

4.9 A home health agency ~~shall~~ may not assign or transfer any authority or designation issued to it by the State Survey Agency.

4.10 A home health agency's designation or re-designation ~~shall~~ will remain in effect for four (4) years unless suspended or revoked by an enforcement action.

4.11 The Department may issue a provisional designation for a period not to exceed one (1) year for a home health agency seeking initial Medicare certification.

4.12 A home health agency ~~shall~~ must post its proof of designation in a location where it will be readily visible to visitors on those premises where its business operations are conducted.

V. Re-designation

5.1 A home health agency ~~shall~~ must submit to the Department a completed renewal application at least 60 calendar days prior to the

expiration of the current designation.

5.2 The Department ~~shall~~ will review the renewal application and, based upon its review, inform the home health agency in writing of its decision to:

(a) Renew the designation for a period of four (4) years;

(b) Grant the home health agency a conditional or provisional designation; or

(c) Deny the application.

5.3 The Department may grant a conditional designation at any time.

5.4 A conditional designation ~~shall~~ will specify the timeframe and terms of the conditional designation.

VI. Governing Bodies and Advisory Boards

6.1 A governing body or its designee(s) ~~shall~~ assumes full legal authority and responsibility for the operation of the home health agency. The governing body ~~shall~~ must appoint a qualified Chief Financial Officer or Chief Executive Officer, arrange for professional advice, adopt and periodically review written bylaws or an acceptable equivalent, and oversee the management and fiscal affairs of the home health agency.

6.2 Except as set forth in section 6.3, the board of each not-for profit designated home health agency ~~shall~~ must be representative of the demographic makeup of the area(s) served by the home health agency or by the health care facility governed by the board.

(a) A majority of the members of the board ~~shall~~ must be composed of individuals who have received or currently are receiving services from the home health agency or from the healthcare facility governed by the board and family members of individuals who have received or currently are receiving such services.

(b) The president of the board ~~shall~~ must survey its members annually and certify to the Commissioner that the composition of the governing body or advisory board meets the requirements of this subsection.

(c) The composition of the board ~~shall~~ must be confirmed by the home health agency's annual independent audit.

(d) The board of a not-for-profit home health agency ~~shall~~ must have overall responsibility and control of the planning and operation of the home health agency~~, including, but not limited to, development of the~~

~~local community services plan~~.

6.3 A for-profit home health agency, or multistate home health agency, ~~shall~~ must have a consumer advisory board that is representative of the demographic makeup of the area or areas served by the home health agency in Vermont.

(a) A majority of the members of the consumer advisory board ~~shall~~ must be composed of individuals who have received or currently are receiving services from the home health agency and family members of individuals who have received or currently are receiving such services.

(b) The consumer advisory board president ~~shall~~ must survey board members annually and certify to the commissioner that the composition of the board meets the requirements of this subsection.

(c) The composition of the consumer advisory board ~~shall~~ must also be confirmed by the home health agency's annual independent audit.

(d) The consumer advisory board ~~shall~~ must meet at least twice per year and ~~shall~~ must advise the home health agency's board of directors with respect to planning and operation of the home health agency, and patient needs, and development of the local community services plan.

VII. Requirements of Operations

7.1 A home health agency ~~shall~~ must comply with all applicable state and federal policies, guidelines, laws and regulations. In the event that state and federal regulations differ, the more stringent regulation ~~shall~~ will apply.

~~7.2 A home health agency shall demonstrate compliance with the federal Home and Community-Based Services regulations.~~

~~7.3~~7.2 A home health agency ~~shall~~ must conduct business and ensure delivery of services in compliance with the Americans with Disabilities Act.

7.3 A home health agency ~~shall~~ must not discriminate based on age, sex, race, sexual orientation or gender identity, country of origin, disability, source of payment, geography, or any other basis specified by law.

7.4 Each home health agency must engage in local and state planning and needs assessments, as directed by State and federal law, which may include participating in the development of the Health Resource Allocation Plan

published pursuant to 18 V.S.A. § 9405 and the community health needs assessment conducted in accordance with 26 U.S.C. § 501(r)(3).

~~Local Community Services Plans:~~

~~(a) Each home health agency shall develop a local community services plan that describes:~~

~~(1) The home health care needs of the population within the geographic service area for which the home health agency is designated or wishes to become designated;~~

~~(2) The methods by which the home health agency will meet those needs;~~

~~(3) A schedule for the anticipated provision of new or additional services;~~

~~(4) The resources needed by and available to the home health agency to implement the plan;~~

~~(5) A home health agency's plan for addressing unforeseen interruption of services and for addressing the need for after hours or weekend services to ensure continuity of services;~~

~~(6) How public input was obtained and reflected in the plan; and~~

~~(7) How the final plan shall be made available to the public.~~

~~(b) A home health agency shall revise its local community services plan at least every four (4) years.~~

7.~~6~~5 A home health agency ~~shall~~ must not employ or have a contract with any worker who has a substantiated record of abuse, neglect or exploitation of a child as determined by the Department for Children and Families or a substantiated record of abuse, neglect, or exploitation of a vulnerable adult as determined by the Department. A home health agency ~~shall~~ must conduct background checks, in accordance with the Department's background check policy, on all employees, independent contractors and volunteers that provide direct care to its patients.

7.~~7~~6 A home health agency ~~shall~~ must ensure that staff, services and necessary supplies are available to meet the needs of its patients and that there are established contingency plans in the event of unexpected shortages of scheduled staff or supplies, or disruption in scheduled services.

7.~~8~~7 A home health agency ~~shall~~ must develop, maintain, enforce and, upon

request, provide to the Department policies and procedures concerning, but not limited to:

(a) Admission, transfer, reduction in services and discharge of patients;

(b) Medical supervision and plans of care;

(c) Emergency care;

(d) Patient records and other patient information, including, but not limited to, confidentiality, use, retention, protection, storage, disposition and disclosure;

(e) Personnel, including, but not limited to, qualifications, credential verification, staff orientation, training and evaluation, and, as applicable, policies pertaining to students and volunteers;

(f) Quality improvement and program improvement plans;

(g) Handling complaints and grievances;

(h) Use of electronic records addressing data integrity, confidentiality, security, authentication, non-repudiation, encryption, as warranted, and ability to be audited, as appropriate to the system and type(s) of information;

(i) Supervision of licensed and unlicensed personnel; and

(j) Advance directives.

7.8 A home health agency ~~shall~~ must develop and maintain an emergency management plan describing how it will continue to provide services or arrange for the provision of services (including, but not limited to, crisis response) for its patients in times of emergency, crisis or disaster. The plan ~~shall~~ must identify how the home health agency will address individual patient needs in the event of an unexpected, temporary disruption of services resulting from the emergency, crisis or disaster. A home health agency ~~shall~~ must make its emergency management plan available to the Department upon request.

7.9 A home health agency ~~shall~~ must develop and maintain a technological infrastructure that enables the home health agency to collect information, submit data, conduct needs assessments of patients in its designated area, and perform other required functions in a cost-effective manner.

7.10 A home health agency ~~shall~~ must have written contracts for clinical or direct care services provided on behalf of the home health agency by other home health agencies, independent contractors or sub-contractors. The contracts ~~shall~~ must include:

(a) Names and signatures of parties to the agreement;

(b) Contract term;

(c) Specifications of work to be performed;

(d) Each party's responsibilities, functions and objectives during the contract term;

(e) Payment provisions;

(f) Business Associate Agreement, when applicable;

(g) Statement that the home health agency ~~shall~~ will retain administrative responsibility for services rendered, including, but not limited to, subcontracted services;

(h) Requirement that services ~~shall~~ will be provided in accordance with these regulations and that personnel providing services ~~shall~~ will meet licensing, training and experience requirements and ~~shall~~ will be supervised in accordance with these rules; and

(i) Requirement that the other party to a contract (i.e., home health agency, independent contractor or subcontractor) ~~shall~~ will provide the home health agency with written documentation regarding the amount and type(s) of services provided.

VIII. Required Functions and Administration

8.1 A home health agency ~~shall~~must:

(a) Provide high quality, comprehensive services that are responsive to the population it serves; and

(b) Monitor the services delivered by its contracted service providers.

8.2 A home health agency ~~shall~~ must provide or arrange for the provision of all designated services to all eligible patients within its designated service area and to all eligible patients accepted onto service based on referrals from other designated agencies, subject to ~~state funding limits~~ ability to accept referrals.

8.3 When a home health agency determines that it is unable to provide services to an eligible patient ~~or applicant for services~~, the agency ~~shall~~ must provide information regarding alternative providers that may be able to serve the individual. The home health agency ~~shall~~ must facilitate a referral to the

alternative provider(s) unless the individual objects to the referral, there is no alternative provider that can serve the individual, or the necessary funding for the service(s) is unavailable. In the event the home health agency determines that it cannot provide or arrange for the provision of designated services, the home health agency ~~shall~~ must provide notice to the individual as required below in Section 156.5. In no event will a home health agency be required to provide a service where it cannot meet the patient's needs.

8.4 A home health agency ~~shall~~ must develop a fee schedule which ~~shall~~ must be provided upon request to all patients or their patient representative and to the public.

8.5 A home health agency ~~shall~~ must provide each of its participants in the Global Commitment to Health Section 1115 Demonstration Waiver Choices for Care program written notice of their right to contact and receive assistance from the State Long-Term Care Ombudsman. The notice ~~shall~~ must include the address and telephone number for the State and Regional Long-Term Care Ombudsman.

8.6 A home health agency ~~shall~~ must ensure that the State Long-Term Care Ombudsman or Office of the Health Care Advocate, or representatives of either or both offices, have:

(a) Access to review the patient records of an individual receiving home health services if:

(1) The patient or the patient representative consents; or

(2) The patient is unable to consent to the review and has no patient representative.

(b) Access to review the patient records of an individual receiving home health services as is necessary to investigate a complaint by, or on behalf of, a patient if:

(1) The patient representative refuses to give the permission;

(2) The State Long-Term Care Ombudsman, the Office of the Health Care Advocate, or the representative of either, is authorized by state and federal regulations to access the patient records~~has reasonable cause to believe that the patient representative is not acting in the best interests of the patient~~;. and

(3) The Regional Long-Term Care Ombudsman has obtained the approval of the State Long-Term Care Ombudsman, if

applicable.

~~8.7 A home health agency shall report critical incidents involving its patients to the Division of Licensing and Protection (DLP) Survey and Certification Unit by the next business day after it learns of the incident. Verbal reports shall be followed by written reports that summarize the incident.~~

8.7~~(a)~~ A home health agency, as a mandatory reporter, ~~shall~~ must report or cause a report to be made ~~to the DLP's Adult Protective Services Unit~~ in accordance with the provisions of 33 V.S.A. § 6903 and 33 V.S.A. § 6904 when it knows of or has received information of abuse, neglect or exploitation of a vulnerable adult, or when it has reason to suspect that a vulnerable adult has been abused, neglected, or exploited. The report ~~shall~~ must be made within 48 hours.

8.8~~(b)~~ If a member of a home health agency staff qualifies as a mandatory reporter pursuant to 33 V.S.A. § 4913, the staff member ~~shall~~ must report to the Department for Children and Families within 24 hours of when it reasonably suspects a child is being abused, neglected, or exploited, in accordance with 33 V.S.A. Chapter 49.

8.9 A home health agency shall report critical incidents involving its patients to the Division of Licensing and Protection (DLP) Survey and Certification Unit by the next business day after it learns of the incident. Verbal reports shall be followed by written reports that summarize the incident.

8.~~8~~10 A home health agency ~~shall~~ must cooperate and collaborate with Vermont Emergency Management Services ("EMS") personnel in its designated service area, as needed.

8.~~9~~11 A home health agency ~~shall~~must:

(a) Monitor and submit reports as requested by the Department regarding the provision of services, including, but not limited to, costs, outcomes, service accessibility and service delivery;

(b) Submit reports as requested by the Department regarding quality assurance, quality improvement, and outcome activities; and

(c) Protect confidentiality of its patient information when data are transferred by ensuring that the method of transferring the information is in compliance with state and federal laws and regulations.

8.~~10~~12 A home health agency ~~shall~~ must establish mechanisms for the

collection of data to be reported on an annual basis to the Department. Data to be collected and reported ~~shall~~ must include, but not be limited to, the following information:

(a) Complaints;

(b) Number of individuals on waiting lists for services;

(c) Number of individuals ineligible for services;

(d) Number of patients under the age of 65 currently receiving services and the number that have received services since the last reporting cycle;

(e) Number of patients 65 years of age and older currently receiving services and the number that have received services since the last reporting cycle;

(f) Total number of visits and visiting hours provided to patients;

(g) Charitable and subsidized programs and services available through the home health agency for uninsured or low-income persons; and

(h) Other quality indicators or data deemed relevant by the Commissioner to monitor and evaluate access to, and the cost and quality of, home health services provided by each home health agency.

8.~~11~~13 The home health agency ~~shall~~ must provide the Department, at the Department's request, with the results of patient surveys, data from federal and state surveys, scoring by national accrediting organizations, audited annual financial statements and annual cost reports. The home health agency ~~shall~~ must provide the results to the Department within ten (10) business days of its receipt of the Department's request.

IX. Fiscal Management

9.1 A home health agency ~~shall~~ must have fiscal management practices that demonstrate cost efficiency and cost controls and that include, at a minimum, the following:

(a) The ability to meet payroll and pay bills in a timely fashion;

(b) Reasonable efforts to collect all fees from individuals and third-party payers;

(c) Financial records and accounting practices that are maintained in accordance with generally accepted accounting principles; and

(d) Insurance coverage for fire, professional liability, general liability, and directors/officers' liability.

9.2 A home health agency ~~shall~~ must provide the Department with sufficient financial detail about home health agency services for purposes of collaborating with the Department to analyze data, costs and efficiencies of home health agency services paid for by the State.

9.3 A home health agency ~~shall~~ must disclose to the Department the information required in its application, as reflected in Section 4.5 above, at the time of the home health agency's initial request for designation, at the time of every survey, and at the time of any change in ownership or management.

X. Petitions to Commissioner

10.1 A home health agency may petition the Commissioner to cease providing [a] designated service(s), with 90 calendar days' notice, when an agency can demonstrate that financial losses from the home health service threaten the continued operation of the home health agency, disregarding private donations and municipal and town funds.

10.2 A home health agency experiencing financial distress may petition the Commissioner for temporary financial relief. The Commissioner, in his or her discretion, and if funds are available, may grant such temporary financial relief after a review of the home health agency's financial status. The temporary financial relief ~~shall~~ will be based upon a plan to correct the issues that led to the home health agency's financial distress. The plan of correction ~~shall~~ must be developed by the home health agency and approved by the Department before any financial assistance is provided.

XI. Skilled Services

11.1 A home health agency ~~shall~~ must furnish skilled services according to the Medicare Conditions of Participation (CoPs) and in accordance with the patient's plan of care. The Medicare HHA CoPs do not apply to those individuals who receive only ~~chore services or other non-medical services.~~ unskilled services.

~~XII. Unlicensed Caregiver Services~~

~~12.1 If a home health agency provides or arranges for unlicensed caregiver services, those services shall must be provided pursuant to a patient's plan of~~

~~care in accordance with state and federal program standards and shall must include, but not be limited to, personal care services and/or homemaker services.~~

~~12.2 A home health agency shall must asensure the competency of the unlicensed caregivers it employs, train those caregivers to perform specific tasks for specific patients, and ensure that the caregivers are appropriately supervised by a qualified supervisor, as provided for in the agency's policies and job descriptions.~~

XII~~I~~. Shared Service Agreements and Referrals

~~13.1~~12.1 A home health agency may enter into shared services agreements with other home health agencies to provide or arrange for the provision of home health services that it would otherwise not offer, or to provide services more efficiently or effectively.

~~13.2~~12.2 Prior to the implementation of a shared service agreement, a home health agency ~~shall~~ must submit the proposed agreement in writing to the Commissioner for approval.

~~13.3~~12.3 The Commissioner ~~shall~~ will have 60 calendar days from receipt of a shared services agreement within which to provide written approval or disapproval of the plan to the home health agencies proposing the agreement.

~~13.4~~12.4 A home health agency ~~shall~~ must initiate communication with each patient by the close of the next business day after the receipt of a physician order, or as specified by the physician order.

XI~~V~~II. Change in Status: Ownership, Location or Discontinuation of Operation or Designated Services

~~14.1~~13.1 When a change of ownership or location is planned, the home health agency is required to file a new application for designation at least 90 calendar days prior to the proposed date of the change.

~~14.2~~13.2 A home health agency ~~shall~~ must apply for a new CON when greater than 50% ownership interest in the home health agency is transferred or conveyed and ~~shall~~ must provide the Department with a copy of the newly issued CON.

~~14.3~~13.3 A home health agency that intends to discontinue all or part of its operation or designated services~~, including, but not limited to, ceasing participation in the Global Commitment to Health Section 1115 Demonstration Waiver Choices for Care program,~~ or intends to transfer ownership or change the location or address of the agency in such a way as to necessitate the

discharge of patients, ~~shall~~ must provide written notice as outlined below. The home health agency is responsible for ensuring that all patients are discharged in a safe and orderly manner.

(a) General Notice Requirements

(1) At least 90 calendar days prior to the proposed date of any such change, a home health agency ~~shall~~ must provide written notice to the Department, the Office of the Health Care Advocate and the State Long-Term Care Ombudsman.

(2) At least 60 calendar days prior to the proposed date of any such change a home health agency ~~shall~~ must place a legal notice in local area newspapers. The notice ~~shall~~ must include the date of the intended change, and, if the change involves closure of a program or the home health agency, the date upon which the home health agency will no longer accept patients.

(3) At least 45 calendar days prior to the proposed date of any such change, a home health agency ~~shall~~ must provide a detailed written plan to the Department, the Office of the Health Care Advocate and the State Long-Term Care Ombudsman describing how the home health agency intends to provide for the safe and orderly transfer to other service providers or discontinuation of services for its patients. The plan ~~shall~~ must include:

(i) Assurances that adequate staff and patient care will be provided during the transfers;

(ii) Arrangements to ensure the orderly transfer of patients to another service provider(s); and

(iii) A protocol for disposition of patient files and home health agency records.

(4) Upon request, the home health agency ~~shall~~ must provide to the Department any additional information related to the transfer to other service providers or the discontinuation of designated services or its operations plan, as well as follow-up reports regarding specific placement action.

(b) Patient Notice Requirements.

(1) At least 60 calendar days prior to the proposed date of any change that would necessitate discontinuation of a designated service or transfer to another service provider, a home health

agency ~~shall~~ must provide written notice to all patients or their patient representatives receiving the designated service(s).

(2) The notice ~~shall~~ must be provided on forms approved by the Department for non-Medicare services. The notice ~~shall~~ must include:

(i) The reason for the discontinuation of the designated service(s) or transfer to another service provider;

(ii) The date the designated service(s) will be discontinued or the transfer to another service provider will occur; and

(iii) Information about how to contact the Office of the Health Care Advocate and State Long-~~t~~Term Care Ombudsman.

(3) At least 30 calendar days prior to closure of the home health agency or discontinuation of a designated service, a home health agency ~~shall~~ must provide to each patient receiving the designated service an individualized plan to ensure continuity of care.

(c) In the event of a home health agency closure or discontinuation of a service(s), all home health agency rules and regulations ~~shall~~ will remain fully applicable until all patients have been transferred to other service providers.

(d) When a home health agency intends to make a change (e.g., admission or retention policy, ownership, or location of the agency) in such a way that does not necessitate the discharge of patients or transfer to another service provider, the home health agency ~~shall~~ must provide written notice to the Department and to the patient(s) at least thirty (30) days prior to such a change.

XIV. Notice to Patients and Public Regarding Suspension/Revocation/Non-Renewal of Designation Status

~~15.1~~14.1 If a designation is suspended, revoked, or not renewed, a home health agency ~~shall~~ must notify all its patients in writing about the action within 5 days of receipt of the notification of a suspension, revocation or non-renewal. The notice ~~shall~~ must include the date of the suspension, revocation or non-renewal and, if the change involves closure of a program or the home health agency, the date upon which the home health agency will no longer accept patients and the effective date of closure, if applicable.

~~15.2~~14.2 If a designation is suspended, revoked, or not renewed, a home

health agency ~~shall~~ must advise the public of such action. The public notice ~~shall~~ must be in the form of a paid legal notice in the local area newspaper(s), published within 15 calendar days following receipt by the home health agency of written notification of the suspension, revocation or non-renewal of the designation.

XV~~I~~. Admissions, Denials, Reduction of Services, Discharge of Patients and Notice

~~16.1~~15.1 A home health agency ~~shall~~ must develop and implement policies and procedures that set forth the steps that the home health agency will follow regarding:

(a) denial of an admission for designated home health services (as used in this Section, a "denial");

(b) reduction of services for patients; and

(c) discharge of patients.

~~16.2~~15.2 Discharge planning for patients ~~shall~~ must be initiated at the time of admission of a patient to home health services and ~~shall~~ must be provided as part of the ongoing assessment of a patient's continuing care needs and in accordance with expected patient care outcomes.

~~16.3~~15.3 When a home health agency denies an application for admission, or reduces the services being provided to an existing patient or discharges an existing patient from services pursuant to 15~~6~~.4(a), 15~~6~~.4(b) or 15~~6~~.4(c), the home health agency ~~shall~~ must provide a verbal notice followed by a written notice, to the patient and patient representative as applicable. Notices ~~shall~~ must be accessible and written in language that is understandable to a layperson. The home health agency ~~shall~~ must provide verbal notice to the patient and patient representative, if applicable, either in person or by telephone. The home health agency ~~shall~~ must provide written notice by hand-delivery or by mailing the notice to their last known mailing addresses. ~~For patients placed on a waiting list for homemaker services, a verbal notice alone shall~~ will suffice.~~

~~16.4~~15.4 A home health agency may reduce the designated services being provided to an existing patient or discharge an existing patient from services only as provided for in this subsection:

(a) A home health agency may reduce the designated services being provided to an existing patient or discharge an existing patient from services with verbal and written notice as soon as practicable when one (1) or more of the following occurs:

(i) The patient has requested that the home health services be reduced or that the patient be discharged from services;

(ii) The patient has moved out of the home health agency's designated service area;

(iii) The patient has chosen another provider, and arrangements have been made for the alternate provider to assume responsibility for the home health care needs of the patient; or

(iv) The patient is admitted to a hospice, hospital, nursing home, residential care home, or rehabilitation facility;

(b) A home health agency may reduce the designated services being provided to ~~an~~ an existing patient or discharge ~~an~~ an existing patient from services with written notice at least 2 business days before the reduction in or discharge from services when one (1) or more of the following occurs:

(i) Goals and treatment objectives have been met, and skilled services are no longer medically necessary as determined by the physician and reflected in the physician's orders;

(ii) The home health agency has been notified by the third-party payer, the patient or the case manager that the patient no longer meets the eligibility requirements for the services, or the services are no longer authorized or covered by the patient's health insurance plan; or

(iii) The home health agency has documented its unsuccessful efforts ~~been unable~~ to obtain written orders for skilled services from the patient's physician.

(c) A home health agency may reduce the designated services being provided to ~~an~~ an existing patient or discharge ~~an~~ an existing patient from services with written notice at least 14 calendar days before the reduction in or discharge from services when one (1) or more of the following occurs:

(i) The patient has failed to pay for services for which he or she is responsible;

(ii) After attempting to resolve the situation, the home health agency determines and documents that the patient's needs cannot be adequately met in the home by the home health agency; or

(iii) The patient, primary caregiver or other person in the home has exhibited behavior, including, but not limited to, physical abuse, sexual harassment, verbal threats or abuse, or threatening behavior that poses a safety risk to agency staff.

(d) A home health agency may reduce services or discharge a patient immediately and without advance notice if the patient, primary caregiver or other person in the home has exhibited behavior which presents an imminent risk of harm to agency staff.

(e) In emergency situations, when the home health agency cannot reasonably provide advance notice, the agency must provide verbal and written notice as soon as practicable.

~~16.5~~15.5 The written notice of a denial of admission to home health services, a reduction in existing home health services, or a discharge from services, ~~shall~~ must include the following information:

(1) The specific reason(s) for the denial, reduction of or discharge from services;

(2) The effective date of the decision to reduce services or discharge a patient from services;

(3) Specific information about *how* to appeal, in accordance with Section XXII~~I~~. of these regulations;

(4) Contact information for the Office of the Health Care Advocate and the Office of the State Long-Term Care Ombudsman;

(5) A statement that, while an appeal is pending, the patient may request to continue existing services only, or a statement that no services are available for appeals of the denial of admission to home health services; and

(6) A statement that a request for continuing services, if any, following a reduction in or discharge from services under circumstances listed in Section 1~~6~~5.4(c)(ii) or (iii), ~~shall~~ must be made to the Division of Licensing and Protection's State Survey Agency and must be made before the effective date of the intended action.

~~16.6~~15.6 A home health agency ~~shall~~ must provide for the following when discharging a patient to protect the safety of staff pursuant to Section 1~~5~~6.4(c)(iii).

(a) When discharging a patient from services pursuant to Section 156.4(c)(iii) above, the home health agency ~~shall~~must:

(1) notify the physician, if working under a physician's order, and the case manager, if applicable, of the reason for discharge (i.e., safety concerns);

(2) advise the patient and the patient representative, if applicable, verbally and in writing, that a discharge from services for safety reasons is being pursued~~considered~~, explaining the specific safety issue that is the cause of the discharge; ;

(3) demonstrate and document in the patient's medical record that a reasonable effort has been made to resolve the problem(s) presented by the patient's behavior or the situation that caused safety concerns; and

(4) document in the patient's record the problem(s) and efforts made to resolve the problem(s).

(b) When, based on the specific circumstances, there is an immediate need to reduce services or to discharge a patient from services due to an imminent risk of harm and the home health agency cannot reasonably provide advance notice, the home health agency need not comply with the requirements set forth in 156.5 and 156.~~7~~10. Rather, the home health agency must adequately document the basis for its determination that an immediate need to discharge or reduce services existed. The determination as to an immediate need to discharge or reduce services ~~shall~~ must be based on an assessment by the home health agency that risk of harm to the home health agency staff providing the services is imminent. The home health agency ~~shall~~ must notify the physician, if working under a physician's order, and the case manager, if applicable, of the reason for discharge (i.e., safety concerns);

(c) The home health agency ~~shall~~ must provide verbal and written notice to the patient and the patient representative, if applicable, as soon as practicable immediately following the determination to discharge from or reduce services based on an imminent risk of harm. The notification ~~shall~~ must explain:

(1) the description of the imminent risk of harm;

(2) the basis for the discharge from or reduction of services;

(3) the reason why advance notice was not given;

(4) the effective date of the reduction of services or discharge from services;

(5) what steps, if any, the patient may take to remediate the situation such that services may be restored;

(6) specific information about how to appeal, in accordance with Section XXII~~I~~ of these ~~regulations~~rules, including, but not limited to, a statement that the patient may request that services currently in place continue while the appeal is pending, if applicable, and that continuing services are not available unless and until the imminent risk of harm has been remediated.

(7) Contact information for the Office of the Healthcare Advocate and the Office of the State Long-Term Care Ombudsman.

15.7 If an individual was previously discharged from service by a home health agency in accordance with 15.4(c)(iii) or 15.4(d), and the behavior or conditions causing the discharge cannot be reasonably mitigated or eliminated, a home health agency, upon receipt of a subsequent request to admit the individual, may:

(a) deny the new admission for service; or

(b) accept the admission~~,~~ but decline to send a home health agency employee to make a visit if the home health agency has reason to believe that the individual who exhibited behavior that resulted in the discharge is present in the home.

15.8 A home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated pursuant to Section 15.7; however, if a home health agency employee declines to enter the home, the home health agency must provide the patient verbal notice and, within 5 business days, written notice, detailing the reasons for its decision.

15.9 If a home health agency denies a new admission for service, pursuant to 15.7(a), it must provide written notice to the patient and the patient representative, if applicable. The notice ~~shall~~ must include:

(a) The reason for the denial of service;

(b) Information about how to file a complaint in accordance with

Section 17.16 of these regulations; and

(c) Contact information for the Office of the Health Care Advocate and the Office of the Long-Term Care Ombudsman.

~~16.7~~15.10 When a home health agency determines that a patient will require continuing care after services are discontinued, the agency ~~shall~~ must arrange, with the patient's consent, or actively assist the patient with arranging for such services. The home health agency ~~shall~~ must document its efforts to arrange for, or assist the patient with arranging for, continued care in the patient's clinical record, and ~~shall~~ must provide sufficient clinical information to the receiving entity to assure continuity of care and services. The home health agency ~~shall~~ must educate the patient about how to obtain further care, treatment and services to meet his or her identified needs, if applicable.

~~16.8~~15.11 A home health agency ~~shall~~ must follow the CMS regulations governing notices and appeal rights when the home health agency reduces Medicare covered services for a patient or discharges a patient receiving only Medicare-covered services.

~~16.9~~15.12 When a home health agency discharges a patient from services for any of the circumstances specified in this section, the circumstances ~~shall~~ must be documented in the patient record.

~~16.10~~15.13 In addition to the requirements of this section, in the event that a home health agency discontinues offering a service (other than a designated service) or ceases operation, notice ~~shall~~ must be provided in accordance with Section 1~~3~~4.3 above.

XVI~~I~~. Patient Assessment and Plan of Care

~~17.1~~16.1 All Medicare Certified Services ~~shall~~ must follow the Medicare CoPs for the patient assessment and development of the plan of care.

~~17.2~~16.2 The patient assessment and plan of care regarding programs not covered by Medicare will follow the applicable program standards. In the absence of standards, the home health agency will respond to referrals in two business days.

~~17.3~~16.3 A patient's plan of care ~~shall~~ must be person-centered, understandable to a layperson, and formatted in a form accessible to the patient and the patient representative, if applicable.

~~17.4~~16.4 A home health agency ~~shall~~ must ~~as~~ensure that services are furnished to the patient in accordance with the patient's plan of care.

~~17.5~~16.5 A home health agency ~~shall~~ must respond in a timely manner to patient requests regarding his or her plan of care, including, but not limited to, requests for care conferences or changes in service. Home health agencies ~~shall~~ must respond as soon as practicable.

~~17.6~~16.6 A home health agency ~~shall~~ must consider a patient's preferences for services and caregivers and ~~shall~~ must collaborate with the patient's other service providers, service agencies or service systems, if appropriate and requested by the patient.

XVII~~I~~. Patient Rights

~~18.1~~17.1 A patient has the right to receive a timely response to his or her request for services from the home health agency.

~~18.2~~17.2 A patient has the right to be fully informed by the home health agency of all of his or her rights and responsibilities associated with the provision of care by the home health agency. ~~—~~A patient has the right to receive written notice from the home health agency of patient rights during the initial visit or before care is furnished or any time at the patient's request~~.~~

~~18.3~~17.3 A patient has the right to appropriate and professional care in accordance with appropriate standards of care.

~~18.4~~17.4 A patient has a right to receive care and treatment free of maltreatment, including, but not limited to, abuse, neglect and exploitation.

~~18.5~~17.5 A patient has the right to participate in care planning and in that care, to be informed by the home health agency in advance of changes in care and to be informed of the type of providers that will provide care and the frequency of visits.

~~18.6~~17.6 A patient has the right to refuse treatment within the confines of the law and to be informed of the consequences of that action.

~~18.7~~17.7 A patient has the right to be informed of his or her right to formulate advance directives.

~~18.8~~17.8 A patient has the right to confidentiality of his or her protected health information and the right to review his or her patient record upon request.

~~18.9~~17.9 A patient has the right to have his or her property and person respected by the home health agency.

~~18.10~~17.10 A patient has the right to be informed about how to contact the home health agency at all times.

~~18.11~~17.11 A patient has the right to be informed by the home health agency of the telephone number for the toll-free home health hotline. The home health agency ~~shall~~ must inform the patient that the purpose of the hotline is to receive complaints or questions about local home health agencies.

~~18.12~~17.12 A patient has the right to receive from the home health agency an admission packet that includes relevant information, including, but not limited to, the contact information for the Office of the Health Care Advocate or, if the patient receives services under the Global Commitment to Health 1115 Medicaid Waiver as a Choices for Care program participant, the State Long-Term Care Ombudsman.

~~18.13~~17.13 A patient has the right to be fully informed of home health agency policies and charges for services, including, but not limited to, eligibility for third-party reimbursements. Before the care is initiated, the home health agency ~~shall~~ must inform the patient of:

(a) The extent to which payment may be expected from Medicare, Medicaid, any other federally funded program, or any State program or private insurance known to the home health agency; and

(b) The charges that may be the responsibility of the patient.

~~18.14~~17.14 A patient has the right to voice grievances and request changes in services or staff without fear of retaliation or discrimination by the home health agency.

~~18.15~~17.15 A patient has the right to appeal a notice of discharge from or reduction in home health agency services or a denial of admission to the home health agency and to receive information about the appeal process.

~~18.16~~17.16 A patient has the right to file complaints with the Division of Licensing and Protection. If dissatisfied with the resolution of the complaint, the patient may ask for the decision to be reviewed by the Commissioner.

~~18.17~~17.17 A patient has the right to review reports of state and federal surveys of the home health agency and ~~a~~the right to receive copies of the survey reports upon request to the Division of Licensing and Protection.

~~18.18~~17.18 Any of the rights enumerated in this section may be exercised by an individual who has the legal authority (e.g., patient representative) to act on behalf of the patient, when the patient lacks the capacity to exercise those rights.

X~~VIII~~IX. Quality Assurance and Improvement

~~19.1~~18.1 A home health agency ~~shall~~ must establish an effective, ongoing, data-driven quality assessment and performance improvement program that reflects the full range of home health agency services, including, but not limited to, those services furnished under contract or other formal or informal arrangement. The program ~~shall~~must:

(a) Include an ongoing measurable data collection system that tracks and focuses on indicators to improve patient outcomes and reduce errors;

(b) Measure, analyze, and track quality indicators, including, but not limited to, adverse patient events, existing or potential problems, and other performance indicators that assess quality, effectiveness and efficiency of agency services and operations;

(c) Identify changes that will lead to improvement;

(d) Implement quality improvement(s) and corrective action(s);

(e) Evaluate results of quality improvement(s) and correction action(s); and

(f) Assure systemic integration of successful quality improvement actions and corrective action(s).

~~19.2~~18.2 The frequency and detail of data collection ~~shall~~ must be specified by the governing body or board of the home health agency and ~~shall~~ must include detail and data as needed and specified by the Department.

~~19.3~~18.3 A home health agency ~~shall~~ must participate in the Department's Quality Review processes and monitoring activities. The home health agency ~~shall~~ must respond in a timely and effective manner to recommendations made in the Department reviews and/or other monitoring reports.

~~19.4~~18.4 A home health agency ~~shall~~ must establish program priorities for performance improvement activities that:

(a) Focus on high risk, high-volume, or problem prone areas;

(b) Consider the incidence, prevalence, and severity of problems in those areas;

(c) Focus on practices that affect patient safety; and

(d) Identify trends in tracked errors and adverse patient events.

~~19.5~~ 18.5 A home health agency ~~shall~~ must obtain and monitor patient and family satisfaction, keep written records of all of its monitoring efforts, and document the use of this information through quality improvement activities.

These written records ~~shall~~ must be made available to the Department upon request.

~~19.6~~ 18.6 A home health agency's quality assurance and improvement activities ~~shall~~ must include, but not be limited to, involvement by direct care staff in the identification and planning of quality improvement activities.

XIX. Survey and Review

~~20.1~~19.1 The Department ~~shall~~ will survey a home health agency prior to designation and at any other time it considers a survey necessary to determine if an agency is in compliance with these regulations.

~~20.2~~19.2 Regardless of the term of designation, the Department ~~shall~~ will monitor a home health agency for continued compliance with applicable laws and rules on at least an annual basis, except that surveys, at the Department's discretion, need not be conducted during a year when a Medicare certification survey is performed. Surveys may be conducted more frequently in any of the following circumstances:

(a) Change of ownership;

(b) Receipt of complaints; or

(c) Other circumstances that could have an impact on the home health agency's ability to meet the needs of the patients in the designated service area.

~~20.3~~19.3 The Department ~~shall~~ will have access to the home health agency at all times, with or without notice, to conduct investigations. An application for designation, whether initial or renewal, ~~shall~~ will constitute permission for entry into, and survey of, a home health agency by representatives of the Department during the pendency of the application and, if designated, during the period of designation.

~~20.4~~19.4 The Department ~~shall~~ will investigate whenever it has reason to believe a violation of the law or regulations by the home health agency has occurred. Investigations ~~shall~~ will be conducted by the Department and may be conducted at any place or include any person the Department believes possesses information relevant to its regulatory responsibility and authority.

~~20.5~~19.5 After each survey or complaint investigation, the Department ~~shall~~ will hold an exit conference with the Chief Executive Officer or Executive Director of the home health agency. The exit conference ~~shall~~ will include an oral summary of the Department's findings and, if regulatory violations were found, a notice that the home health agency must develop and submit an acceptable plan of correction. The Department ~~shall~~ will post the survey statements on the Department's website.

~~20.6~~19.6 The Department ~~shall~~ will prepare a written report that summarizes the results of the survey. The report ~~shall~~ will be sent to the home health agency upon completion. The report ~~shall~~ will include the following:

(a) A description of each condition that constitutes a violation;

(b) Each rule or statutory provision alleged to have been violated;

(c) The date by which the home health agency must return a plan of correction for the alleged violation(s);

(d) The date by which each violation must be corrected;

(e) Sanctions the Department may impose for failure to correct the violation or failure to provide proof of correction by the date specified;

(f) The right to apply for a variance;

(g) The right to an informal review; and

(h) The right to appeal the determination of violation to the Commissioner within 15 calendar days of the date of the notice of violation.

~~20.7~~19.7 If a home health agency receives a notice of violation(s) from the Department, it ~~shall~~ must submit a written plan of correction to the Department within ten (10) business days of the date of the notice of violation.

(a) A home health agency's plan of correction ~~shall~~ must describe how the agency intends to correct each violation, the expected date of completion, how the plan will be monitored and the person responsible

for overseeing the plan of correction.

(b) A home health agency ~~shall~~ must post statements of deficiencies in a location readily visible to patients and to the public on those premises where the home health agency's business operations are conducted.

(c) The Department may accept the plan of correction as written or may require modification.

~~20.8~~19.8 If, as a result of an investigation or survey, the Department determines that a home care business is operating without designation and meets the definition of a home health agency, written notice of the violation ~~shall~~ will be prepared and provided to the business.

~~20.9~~19.9 Patients, patient representatives and the public ~~shall~~ will have the right to review current and past state and federal survey and inspection reports of the home health agency, and, upon request, to receive a copy of any such report from the home health agency ~~a copy of any such report~~. Copies of reports ~~shall~~ must be available for review during normal business hours at one location in the home health agency. The home health agency may charge an amount for hard ~~the~~ copies of the reports consistent with state record copying costs. The home health agency must provide electronic copies, if requested, at no cost.

XX~~I~~. Enforcement

~~21.1~~20.1 The Department may take immediate enforcement action when necessary to eliminate a condition at a home health agency or a condition that exists through the provision of its services that can reasonably be expected to cause death or serious harm to patients' or staff's health or safety. If the Department takes immediate enforcement action, it ~~shall~~ will explain its actions and the reasons for those actions in the notice of violation.

~~21.2~~20.2 The Department may require a home health agency to take corrective action to eliminate a violation of a rule or statute and provide the Department with proof of correction of the violation(s) within a period of time specified by the Department.

(a) If the Department does require corrective action, the Department may, within the limits of resources available to it, provide technical assistance to the home health agency to enable it to comply with the statutory and regulatory requirements;

(b) If a home health agency has not corrected the violation by the time

specified, the Department may take such further action as it deems appropriate in accordance with these regulations and governing federal and state law.

~~21.3~~20.3 The Department may assess administrative penalties against a home health agency for failure to correct a violation or failure to comply with a plan of corrective action. The Department ~~shall~~ will determine the primary purpose of the rule or provision at issue and may assess administrative penalties in accordance with the daily financial penalties set forth below:

(a) Up to $500.00 for each day a violation remains uncorrected if the rule or provision violated was adopted primarily for administrative purposes;

(b) Up to $800.00 for each day a violation remains uncorrected if the rule or provision violated was adopted primarily to protect the welfare or the rights of patients;

(c) Up to $1000.00 for each day a violation remains uncorrected if the rule or provision violated was adopted primarily to protect the health or safety of patients;

(d) For purposes of imposing administrative penalties under this subsection, a violation ~~shall~~ will be deemed to have first occurred as of the date of the initial notice of violation.

~~21.4~~20.4 The Department may suspend, revoke, modify or refuse to renew a designation of a home health agency ~~up~~on any of the following grounds:

(a) Violation by a home health agency of any of the provisions of the law or regulations;

(b) For committing, permitting, aiding or abetting any illegal practices in the operation of the home health agency or for conduct or practices detrimental to the health, safety, or welfare of patients to whom home health services are provided.

(c) Financial incapacity of a home health agency to provide or arrange for adequate care and services; or

(d) Failure by a home health agency to comply with a final decision or action of the Department.

~~21.5~~20.5 The Department may suspend admissions to a home health agency for a violation that may directly impair the health, safety or rights of patients,

or for operating without designation.

~~21.6~~20.6 The Department, the attorney general, or a patient may bring an action for injunctive relief against a home health agency in accordance with the Rules of Civil Procedure to enjoin any act or omission which constitutes a violation of the law or regulation. Notice of such action ~~shall~~ will be given to the Office of the Health Care Advocate and, if applicable, the State Long-Term Care Ombudsman.

~~21.7~~20.7 The Department, the attorney general, or a patient may bring an action in accordance with the Rules of Civil Procedure for the appointment of a receiver for a home health agency, if there are grounds to support suspension, revocation, modification or refusal to renew the agency's designation. Notice of such action ~~shall~~ will be given to the Office of the Health Care Advocate and, if applicable, the State Long-Term Care Ombudsman.

~~21.8~~20.8 The Department may enforce a final order for appointment of a receiver by filing a civil action in the superior court in the county in which the home health agency is located or in Washington Superior Court.

~~21.9~~20.9 The remedies provided for violations of the law or regulations are cumulative.

~~21.10~~20.10 A person or home health agency that knowingly violates the designation or confidentiality requirements of these rules may be subject to criminal penalties pursuant to 33 V.S.A. §7116.

~~21.11~~20.11 Upon notice of suspension or revocation of a designation, the home health agency ~~shall~~ must immediately surrender the certificate of designation to the Department.

~~21.12~~20.12 The Department, working in collaboration with a home health agency, may appoint a temporary manager to operate a home health agency as a substitute manager. The temporary manager ~~shall~~ will have the authority to hire, terminate or reassign staff, obligate funds, alter agency policies and procedures and manage the provision of home health services to correct operational deficiencies.

(a) A temporary manager may be appointed in the following circumstances:

(1) When the home health agency intends to close, but has not arranged for the orderly transfer of its patients at least 60 calendar days prior to closure;

(2) When an emergency exists in a home health agency which

threatens the health, safety or welfare of its patients; or

(3) When a home health agency is in substantial or habitual violation of the standards of health, safety or patient care established under state or federal regulations to the detriment of the welfare of the patients.

(b) A temporary manager ~~shall~~ must be qualified based on experience and education to oversee the correction of operational deficiencies and ~~shall~~ must not:

(1) Have been found guilty of misconduct by any licensing board or professional society in any state;

(2) Have, nor ~~shall~~ may a member of his or her immediate family have, a financial ownership interest in the home health agency, and;

(3) Currently serve or, within the past 2 years have served as a member of the staff of the home health agency.

(c) A temporary manager's salary ~~shall~~ must be paid directly by the home health agency and ~~shall~~ must be at least equivalent to the sum of the following:

(1) The prevailing salary paid by providers for positions of this type in the home health agency's designated service area;

(2) Additional costs that would have reasonably been incurred by the home health agency if such person had been in an employment relationship; and

(3) Any other costs incurred by such a person in furnishing services under such an arrangement or as otherwise set by the Department.

(d) A temporary manager's salary may exceed the amount specified in subsection (c) above if the Department is otherwise unable to attract a qualified temporary manager within the salary requirements listed in (c) above.

(e) If a home health agency fails to relinquish authority to the temporary manager as described in this section, the Department ~~shall~~ will terminate the designation.

(f) A home health agency's failure to pay the salary of the temporary

manager is considered a failure to relinquish authority to temporary management.

(g) Temporary management ~~shall~~ will end when a home health agency meets the conditions specified in this section and receives approval from the Commissioner or when it is determined that the home health agency will no longer be designated.

XXII. Complaints Received by Home Health Agencies Regarding Staff, Management or Other Service Providers

~~22.1~~21.1 A home health agency ~~shall~~ must investigate complaints regarding its staff or management, or anyone furnishing services or supplies on behalf of the home health agency. The complaints may be submitted to the home health agency by patients, a patient's family, a patient representative, the State Long-Term Care Ombudsman or the Office of the Health Care Advocate. The home health agency ~~shall~~ must furnish patients with the toll-free telephone number for the Home Health Hotline to report complaints.

~~22.2~~21.2 The home health agency ~~shall~~ must respond to all complaints, whether received orally or in writing, within two (2) business days of receiving the complaint(s).

~~22.3~~21.3 A home health agency ~~shall~~ must keep a log of all complaints. The log ~~shall~~ must include the date of the complaint(s), the name of the complainant(s), the subject of the complaint(s), the name of the person assigned to investigate the complaint, and the date and resolution of the complaint(s).

~~22.4~~21.4 A home health agency ~~shall~~ must report to the Division of Licensing and Protection any quality of care or service-related complaint not resolved to the satisfaction of the patient within 8 business days of the home health agency receiving the complaint.

~~22.5~~21.5 When a quality of care or service-related complaint is not resolved to the satisfaction of the patient within five (5) business days, a home health agency ~~shall~~ must notify the complainant in writing of the right to request assistance from the Office of the Health Care Advocate or, if applicable, the State Long-Term Ombudsman and provide the contact information for those offices. If both the home health agency and the patient are actively seeking resolution but the issue(s) is(are) not resolved within 30 calendar days of receiving the complaint, the home health agency ~~shall~~ must notify the patient in writing that he or she may complain to the Department at that time.

XXIII. Patient Appeals

~~23.1~~22.1 A patient or the patient representative, if applicable, who is notified by CMS of a reduction in or a discharge from Medicare services must follow the appeals process outlined in the written notification from CMS.

~~23.2~~22.2 A patient or the patient representative, if applicable, who is notified by Medicaid or another third-party payer of a reduction in or a discharge from services must follow the appeals process outlined by the payer.

~~23.3~~22.3 ~~A patient or the patient representative, if applicable, who is notified by a home health agency of a denial of an application for admission, reduction of or discharge from services, and plans to appeal that decision must follow the appeals process outlined in this section of the regulations.~~ A patient or the patient representative, if applicable, who is notified by a home health agency of its denial of an application for admission or its reduction of, or discharge from, services, and who plans to appeal the home health agency's decision must follow the appeals process outlined in this section of the rules.

~~23.4~~22.4 To appeal the decision of the home health agency to deny admission to services, or reduce or discharge a patient from services, the patient or the patient representative, if applicable, must, within 30 calendar days of the date of the written notice of decision from the home health agency, contact the Division of Licensing and Protection's State Survey Agency to appeal the home health agency's decision to the Director of the State Survey Agency.

~~23.5~~22.5 The Division of Licensing and Protection's State Survey Agency ~~shall~~ will issue its decision within 30 calendar days of its receipt of the request for appeal. The State Survey Agency may extend the time for resolving an appeal by up to 14 calendar days upon request of the patient or patient representative, or upon showing there is a need for additional information and how the delay is in the best interest of the patient.

~~23.6~~22.6 Copies of all materials submitted to the Division of Licensing and Protection's State Survey Agency by the home health agency ~~shall~~ will be available to the patient or the patient representative, if applicable, upon request.

~~23.7~~22.7 The written decision rendered by the Director of the State Survey Agency at the Division of Licensing and Protection ~~shall~~ will be sent to the patient or patient representative, if applicable, and the home health agency, and ~~shall~~ will include the reason(s) for the decision and a statement that if the decision is not favorable to the patient, the decision may be appealed to the Human Services Board, with information about how to request a fair hearing, and the timeline for requesting an appeal to the Human Services Board. The notice ~~shall~~ will include contact information for the Human Service Board and inform the patient or the patient representative, if applicable, that a request

for a fair hearing may be made either orally or in writing and ~~shall~~ must be directed to the Human Services Board.

~~23.8~~22.8 Upon the request of a patient or patient representative, a home health agency ~~shall~~ must provide or arrange for continuing services for the patient during the pendency of the patient's appeal to the Human Services Board concerning a reduction of or discharge from services if the payment source provides for continuing services. The home health agency ~~shall~~ must document its efforts regarding patients' continuing services in the patient's clinical record. Services ~~shall~~ will not be provided or continued when an immediate need exists to end services due to an imminent risk of harm to the home health agency staff providing the services and the imminent risk of harm has been documented in the patient record and other relevant home health agency records, unless and until the imminent risk of harm has been remediated.

~~23.9~~22.9 There is no right to an appeal if the sole issue is a state or federal law requiring an automatic change adversely affecting some or all patients. A patient retains the right to appeal the application of the law to the facts of an individual's case.

~~XXIII~~V. Home Health Agency Appeals

~~24.1~~23.1 A home health agency aggrieved by a notice of violation may file a request for an informal review with the State Survey Agency. The request must be made to the State Survey Agency within 10 business days of receipt of the notice of violation.

~~24.2~~23.2 A home health agency applying for re-designation or any person, partnership, association or corporation applying for designation, may appeal the Department's decision to take any of the following actions with regard to designation:

(a) The issuance of a conditional designation;

(b) The amendment or modification of the terms of a designation;

(c) The refusal to grant or renew a designation;

(d) The refusal to grant a conditional designation; or

(e) A notice of violation.

~~24.3~~23.3 A home health agency may request a Commissioner's hearing regarding any action by the Department set forth in Section 2~~3~~4.2 above.

(a) The request for a Commissioner's hearing ~~shall~~ must be in

writing and ~~shall~~ must be made within 15 calendar days of the date of the decision or action notice of the Department.

(b) The request for hearing ~~shall~~ must be accompanied by a clear statement of the basis for the request.

(c) Issues not raised in the request for hearing ~~shall~~ may not be raised later in the proceeding or in any subsequent proceeding arising from the same action of the Department.

(d) Proceedings under this section are not subject to the requirements of 3 V.S.A. chapter 25.

~~24.4~~23.4 A home health agency aggrieved by a final decision by the Commissioner may file a request for a fair hearing before the Human Services Board.

(a) A request for a fair hearing ~~shall~~ may be initiated by calling the Human Services Board or by filing a written request for a fair hearing with the Human Services Board within 30 calendar days of the date of the Commissioner's decision.

(b) No appeal may be taken on any issue that was not raised previously in the request for hearing.

XX~~I~~V. Patient Records

~~25.1~~24.1 A home health agency ~~shall~~ must maintain a patient record for every patient receiving home health services from the agency. The patient record ~~shall~~ must include pertinent and comprehensive information regarding the patient's history and current findings as to the patient's condition(s) and status, in accordance with accepted professional standards and in accordance with the requirements of the program under which the patient is served by the home health agency. A home health agency ~~shall~~ must ensure that whenever a patient's advance directive, including a DNR or COLST, is provided to the agency, a copy is included in the patient record. If the home health agency is taking direction from an individual who claims to be a patient's power of attorney or guardian, the home health agency must have a copy of the power of attorney or guardianship documentation in the patient record.

~~25.2~~24.2 A home health agency ~~shall~~ must maintain the confidentiality of all patient records, including, but not limited to, personal and medical information contained in the patient records, and ~~shall~~ must safeguard patient record information against loss or unauthorized use.

~~25.3~~24.3 A home health agency ~~shall~~ must develop written policies and procedures governing the use and destruction of patient records and the

release of information from patient records to a patient or other authorized individual or entity in accordance with state and federal law.

(a) The home health agency ~~shall~~ must obtain the patient's or the patient representative's written consent prior to release of information from the patient record, excepting access to the patient record by authorized employees of the home health agency, or in the case of a patient transfer to another provider or as permitted by law.

(b) The home health agency's policy pertaining to the release of information from patient records ~~shall~~ must establish a reasonable cost, consistent with state record-~~-~~copying costs, for the provision of copies of patient records.

~~25.4~~24.4 A home health agency ~~shall~~ must retain patient records for ten (10) years after the month the cost report to which the records apply is filed with the fiscal intermediary, unless state or federal law stipulates a longer period of time. A home health agency ~~shall~~ must arrange for the retention of the records, in accordance with applicable federal and state laws and regulations, even if the home health agency discontinues operations.

~~25.5~~24.5 If a patient is transferred to a health care facility, the home health agency ~~shall~~ must send a copy of the patient record or patient health abstract with the patient.

~~25.6~~24.6 A home health agency ~~shall~~ must ensure that a patient's advance directive, including a DNR or COLST, is accessible to authorized individuals and that home health agency staff are familiar with the patient's wishes and with the requirement that the patient's wishes and preferences be honored.

XXV. Unlicensed Caregiver Services

25.1 If a home health agency provides or arranges for unlicensed caregiver services, those services must be provided pursuant to a patient's plan of care in accordance with state and federal program standards and must include, but not be limited to, personal care services and/or homemaker services.

25.2 A home health agency must ensure the competency of the unlicensed caregivers it employs, train those caregivers to perform specific tasks for specific patients, and ensure that the caregivers are appropriately supervised by a qualified supervisor, as provided for in the agency's policies and job descriptions.

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RULES FOR
THE
DESIGNATION AND OPERATION
OF
HOME HEALTH AGENCIES

Agency of Human Services
Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive
Waterbury, VT 05671-2020

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This material is available upon request in alternative formats.

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Section

I. General Provisions

1.1 Purpose. It is the purpose of these rules to implement the laws of the State of Vermont ("State") governing the designation, re-designation, and designation revocation of home health agencies, and the minimum program standards for home health agencies.

1.2 Policy. It is the policy of the State to ensure that, subject to available funding from the State, all Vermont residents within the State have access to comprehensive, medically necessary, high quality home health services without regard to the patient's ability to pay. It is further the policy of the State to ensure that such services are delivered in an efficient and cost-effective manner, under a regulatory framework designed to control costs while not compromising quality or duplicating services.

1.3 Statutory Authority. These rules are adopted pursuant to 33 V.S.A. § 6303(a).

1.4 Statement of Intent. Upon the effective date of these rules, all home health agencies in Vermont must adhere to the rules as adopted. Any designated service provided under an approved separate entity is also subject to these rules. Services which are not subject to designation include wellness and prevention services, clinics, and private duty services.

1.5 Exception and Severability. If any provision of these rules, or the application of any provision of these rules, is determined to be invalid, the determination of invalidity will not affect any other provision of these rules or the application of any other provision of these rules.

1.6 Taxes. All home health agencies in Vermont must be in good standing with the Vermont Department of Taxes, pursuant to 32 V.S.A. §3113. Failure to do so will result in the denial or revocation of designation as a home health agency.

1.7 Material Misstatements. A material misstatement related to designation, re-designation or the law governing home health agencies in Vermont made to the State Survey Agency by a home health agency during the designation or re-designation process, or at any time during which the home health agency is an agency in Vermont, may result in the denial of designation or re-designation, designation revocation or other enforcement action.

1.8 Fair Hearing. A person or entity aggrieved by a decision of the Division of Licensing and Protection's State Survey Agency may file a request for a fair hearing with the Human Services Board as provided in 3 V.S.A. §3091.

II. Definitions.

2.1 General Definitions. For purposes of these rules, words and phrases are given their ordinary meanings unless otherwise specifically defined herein.

2.2 Specific Definitions. The words and phrases below, as used in these rules, have the following meanings, unless otherwise indicated:

(a) *Activities of Daily Living* means routine activities related to self-care, including, but not limited to, dressing and undressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility in and around the home and eating.

(b) *Administrator* means an individual, who may also be the supervising physician or registered nurse, who organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff; employs qualified personnel and ensures adequate staff education and evaluations; ensures the accuracy of public information materials and activities; and implements an effective budgeting and accounting system. A qualified person is authorized in writing to act in the absence of the administrator.

(c) *Applicant* means the individual who signs the application for a home health agency designation.

(d) *Applicant for services* means an individual residing in a designated service area requesting services or care from a home health agency.

(e) *Branch Office* means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to the parent agency so that it shares administration, supervision, and services with the parent agency on a daily basis. The branch office is not required to independently meet the Conditions of Participation as a home health agency.

(f) *Clinician orders for life-sustaining treatment* or *COLST* means a clinician's order or orders for treatment, such as intubation, mechanical ventilation, transfer to hospital, antibiotics, artificially administered

nutrition, or other medical intervention. A COLST order is designed for use in outpatient settings and health care facilities and may include a DNR order that meets the requirements of 18 V.S.A. § 9708.

(g) *Commissioner* means the Commissioner of Disabilities, Aging, and Independent Living.

(h) *Complaint* means a concern raised by a patient, a patient's family member or a patient representative, regarding treatment or care that is (or that fails to be) furnished, or regarding the lack of respect for the patient or the patient's property, by the agency or by anyone furnishing services on behalf of the home health agency.

(i) *Conditional designation* means a designation upon which certain requirements for operation have been imposed by the Department of Disabilities, Aging, and Independent Living.

(j) *Critical Incident* means an unexpected occurrence, related to the provision of home health services, involving death, patient suicide, poisoning, and/or serious physical or psychological injury that requires medical treatment or hospitalization. Such incidents may include, but are not limited to, equipment failure, medication error, the misuse of medical devices or restraints or suspected abuse, neglect or exploitation.

(k) *Department* means the Department of Disabilities, Aging, and Independent Living.

(l) *Designated Services* means:

1. Medically necessary, intermittent, skilled home health services provided by Medicare-certified home health agencies of the type covered under Title XVIII (Medicare) or XIX (Medicaid) of the Social Security Act;
2. Hospice services of the type covered under Title XVIII (Medicare) or XIX (Medicaid) of the Social Security Act; and
3. The term "designated services" does not include any other service provided by a home health agency.

(m) *Designation* (for a home health agency) means that the agency has been approved by the Department to provide skilled home health services and hospice services in the state of Vermont.

(n) *Discharge* means the termination of the services provided to a patient by the home health agency.

(o) *Eligible* means the individual meets the clinical and financial criteria for the applicable service or program and the requested care and services are appropriate to be delivered in the home environment.

(p) *Family member* means an individual who is related to a person by blood, marriage, civil union, or adoption, or who considers himself or herself to be family based upon bonds of affection, and who currently shares a household with such a person or has, in the past, shared a household with that person. For purposes of this definition, the phrase "bonds of affection" means enduring ties that do not depend on the existence of an economic relationship.

(q) *For-profit home health agency* means a private home health agency that is not exempt from Federal income tax under Section 501 of the Internal Revenue Code.

(r) *Home health agency* means a for-profit or nonprofit home health care business, certified by the Centers for Medicare and Medicaid Services to participate in Medicare and Medicaid, which provides part-time or intermittent skilled nursing services and at least one of the following other therapeutic services, made available on a visiting basis, in a place of residence used as a patient's home: physical, speech, or occupational therapy; medical social services; home health aide services; or other non-nursing therapeutic services, including, but not limited to, the services of nutritionists, dieticians, psychologists, and licensed mental health counselors.

(s) *Home health services* means the activities and functions of a home health agency that include, but are not limited to, nursing care, physical, occupational or speech therapy, medical social services, or other non-nursing therapeutic services directly related to care, treatment, or diagnosis of patients in the home.

(t) *Homemaker Services* means certain activities that help maintain a safe, healthy environment for persons residing in their homes. These activities include home management services (cooking, cleaning, laundry and related light housework) and supportive services (shopping and errands) essential to maintain the living quarters. Homemaker services may be provided by a home health agency but are not a designated service.

(u) *Instrumental Activities of Daily Living ("IADLs")* means activities that are not necessary for basic functioning but are necessary to live independently. These activities may include, but are not limited to, light housework, preparing and cleaning up after meals, shopping and mobility in the community.

(v) *Medically Necessary Services* means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the patient's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

(1) help restore or maintain the patient's health; or

(2) prevent deterioration or palliate the patient's condition; or

(3) prevent the reasonably likely onset of a health problem or detect an incipient problem.

(w) *Medicare Conditions of Participation* (CoP) means federal regulations with which particular health care facilities must comply in order to participate in the Medicare and Medicaid programs.

(x) *Nonprofit home health agency* means a home health agency exempt from Federal income tax under Section 501 of the Internal Revenue Code.

(y) *Nursing care* means direct and indirect care provided by a registered nurse, licensed practical nurse, or nursing assistant.

(z) *"Patient record" or "Patient records"* mean documents in the custody of the home health agency, written or electronic, that pertain to the care and services provided to patients by a home health agency, whether authored by the home health agency or not.

(aa) *Patient representative* means an individual who is authorized by the patient to communicate with the home health agency on behalf of the patient. A patient representative includes, but is not limited to, an attorney, a representative payee, a guardian, or an agent under a power of attorney or advance directive. Depending on the authority granted by the patient or under state or federal law, a patient representative may support the patient with decision-making, accessing information and conveying concerns for the patient including, but not limited to, grievances, complaints, and appeals, and receiving information from the home health agency on behalf of the patient regarding these matters.

(n) (bb) *Personal Care* means providing or assisting an individual with the Activities of Daily Living that the individual otherwise would be unable to complete. Personal Care services may be provided by a home health agency but are not designated services.

(cc) *Plan of care* means a written description of the steps that will be taken to meet personal, psychosocial, social, nursing, rehabilitative and/or medical needs of the patient.

(dd) *Plan of correction* means the home health agency's response to the statement of deficiencies issued by the State Survey Agency that describes the steps the agency will take to achieve regulatory compliance.

(ee) *Poisoning* means the ingestion of any toxic substance that impairs health or destroys life when ingested, inhaled or absorbed in a relatively small amount.

(ff) *Provisional designation* means a temporary designation approval from the Department of Disabilities, Aging and Independent Living for not more than one year for a home health agency seeking initial Medicare certification.

(gg) *Shared Services Agreement* means cooperative arrangements between or among two or more home health agencies, which are approved by the Commissioner or the Commissioner's designee, to pool or share one or more home health services, including, but not limited to, skilled services, for the purpose of addressing the special needs or exceptional circumstances of patients located in one or more of their designated services areas or obtaining cost savings and efficiencies for the benefit of patients.

(hh) *Skilled services* means medically necessary services that require the skills of a qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists and speech-language pathologists. Skilled services must meet the Medicare Conditions of Participation and must be provided directly by, or under the general supervision of, these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

(ii) *Unskilled services* means services that are non-medical and do not require professional licensure or a medical provider's orders. These services include, but are not limited to, personal care, homemaker, respite, and companionship services. Unskilled services are not designated services.

(jj) *Variance* means a written determination from the State Survey Agency, based upon the written request of a licensee, which, temporarily and in limited, defined circumstances, waives compliance with a specific regulation.

III. Variances

3.1 Variances from these rules may be granted upon a determination by the State Survey Agency, the Commissioner, or Commissioner's designee. It is incumbent upon the home health agency to demonstrate that:

(a) strict compliance would impose a substantial hardship on the home health agency or the patient; and

(b) any hardship alleged to result from imposition of a rule from which a variance is sought was not created by the home health agency; and

(c) the home health agency will otherwise meet the goal or satisfy the intent of the rule that is the subject of the variance request and the relevant statutory provision.; and

(d) a variance will not result in decreased services to the patients served by the agency, nor will it result in a decrease in the protection of the health, safety or welfare of the patients served by the agency; and

(e) a variance will not conflict with other legal requirements.

3.2 Requests for a variance must be submitted to the State Survey Agency in writing. The request must include:

(a) the citation for the rule that is the subject of the variance request; and

(b) the reason(s) why the variance is being requested, and

(c) a description of the alternative method proposed for meeting the intent of the rule that is the subject of the variance request.

3.3 A variance will not be granted from a rule pertaining to patient rights.

3.4 Variances are subject to review and termination by the State Survey Agency at any time.

IV. The Designation Process

4.1 Any person, partnership, association or corporation, including a home health agency established outside of Vermont, seeking to become a home health agency in Vermont must apply for and obtain a Certificate of Need ("CON") from the Green Mountain Care Board ("GMCB") prior to filing an

application for designation with the Department.

4.2 Any person, partnership, association or corporation, including a home health agency established outside of Vermont, seeking to become a home health agency in Vermont must, in addition to obtaining a CON from the GMCB, obtain and maintain federal certification as a home health agency by the Centers for Medicare and Medicaid Services ("CMS") prior to filing an application for designation with the Department. If nationally accredited and deemed, the home health agency must provide the Department with documentation of that status and notify the Department of any change in status and the reason for the change in status.

4.3 Any person, partnership, association or corporation, including a home health agency established outside of Vermont, seeking to become a home health agency in Vermont, must, after obtaining a CON from the GMCB, file an application for designation with, and obtain approval from, the Department prior to the commencement of such operation.

4.4 Applications to become a home health agency in Vermont must be submitted upon forms approved by the Department.

4.5 A home health agency's application for designation must include:

(a) The legal name of the home health agency, as registered with the Secretary of State's Office; the name under which it will be doing business; its physical address; and, if applicable, the name of the corporation, association or other company responsible for the management of the home health agency;

(b) A completed disclosure of ownership form (obtained from the Department);

(c) A list of all board members, officers, partners, and key administrative staff and their titles, including the names of the administrator and the director of nursing or equivalent, with copies of current licenses;

(d) Proof of CON for the geographic service area where designation is sought;

(e) Proof of Medicare home health agency certification;

(f) The number of full-time equivalent employees by discipline;

(g) An organizational chart showing all reporting and supervisory relationships;

(h) Other information, data, statistics or schedules as the Department may request, including, but not limited to, information on accounts, salaries, tax status and evidence of financial solvency;

(i) The name of each person, firm or corporation having direct or indirect ownership interest of 5% or more in the home health agency, specifying the amount, and the name of each physician with financial interest or ownership of any amount in the home health agency, specifying the amount;

(j) A list of specific services provided by the home health agency, and a list of those services the home health agency arranges for the provision of by contract; and

(k) A sample home health services admission packet.

4.6 When an applicant is a corporation, the application must be signed by two (2) officers of the corporation and by the corporation's Chief Executive Officer or Executive Director, all of whom must have the authority to legally bind the corporation.

4.7 The Department will consider each of the following factors in determining whether a home health agency's application or re-application will be approved for designation or re-designation, as applicable:

(a) CON determination;

(b) Record of compliance with, or violation of, any relevant regulations and laws;

(c) Adherence to accepted professional standards and principles in the provision of services;

(d) Financial status and proof of fiscal responsibility, as shown through:

(1) an annual audit report, which includes an unqualified opinion from an independent auditor and indicates that a home health agency is in compliance with generally accepted accounting standards and that the financial reports are an accurate representation of the agency's financial condition;

(2) credit reports;

(3) history of tax withholding;

(4) history of financial fraud with any third-party payer or vendor;

(5) history of inappropriate referral arrangements; and

(6) compliance with the financial terms and conditions of all state contracts;

(e) Current standing with state and federal tax departments; and

(f) Engagement in planning and needs assessments, as directed by State and federal law, which may include participating in the development of the Health Resource Allocation Plan published pursuant to 18 V.S.A. § 9405 and the community health needs assessment conducted in accordance with 26 U.S.C. § 501(r)(3).

4.8 A home health agency designated to provide services in Vermont has the obligation and the responsibility to provide or arrange for the provision of all designated services to all eligible patients within its designated geographic area who request services.

4.9 A home health agency may not assign or transfer any authority or designation issued to it by the State Survey Agency.

4.10 A home health agency's designation or re-designation will remain in effect for four (4) years unless suspended or revoked by an enforcement action.

4.11 The Department may issue a provisional designation for a period not to exceed one (1) year for a home health agency seeking initial Medicare certification.

4.12 A home health agency must post its proof of designation in a location where it will be readily visible to visitors on those premises where its business operations are conducted.

V. Re-designation

5.1 A home health agency must submit to the Department a completed renewal application at least 60 calendar days prior to the expiration of the current designation.

5.2 The Department will review the renewal application and, based upon its review, inform the home health agency in writing of its decision to:

(a) Renew the designation for a period of four (4) years;

(b) Grant the home health agency a conditional or provisional

designation; or

(c) Deny the application.

5.3 The Department may grant a conditional designation at any time.

5.4 A conditional designation will specify the timeframe and terms of the conditional designation.

VI. Governing Bodies and Advisory Boards

6.1 A governing body or its designee(s) assumes full legal authority and responsibility for the operation of the home health agency. The governing body must appoint a qualified Chief Financial Officer or Chief Executive Officer, arrange for professional advice, adopt and periodically review written bylaws or an acceptable equivalent, and oversee the management and fiscal affairs of the home health agency.

6.2 Except as set forth in section 6.3, the board of each not-for profit designated home health agency must be representative of the demographic makeup of the area(s) served by the home health agency or by the health care facility governed by the board.

(a) A majority of the members of the board must be composed of individuals who have received or currently are receiving services from the home health agency or from the healthcare facility governed by the board and family members of individuals who have received or currently are receiving such services.

(b) The president of the board must survey its members annually and certify to the Commissioner that the composition of the governing body or advisory board meets the requirements of this subsection.

(c) The composition of the board must be confirmed by the home health agency's annual independent audit.

(d) The board of a not-for-profit home health agency must have overall responsibility and control of the planning and operation of the home health agency.

6.3 A for-profit home health agency, or multistate home health agency, must have a consumer advisory board that is representative of the demographic makeup of the area or areas served by the home health agency in Vermont.

(a) A majority of the members of the consumer advisory board must be composed of individuals who have received or currently are receiving services from the home health agency and family members of individuals

who have received or currently are receiving such services.

(b) The consumer_advisory board president must survey board members annually and certify to the commissioner that the composition of the board meets the requirements of this subsection.

(c) The composition of the consumer advisory board must also be confirmed by the home health agency's annual independent audit.

(d) The consumer advisory board must meet at least twice per year and must advise the home health agency's board of directors with respect to planning and operation of the home health agency, and patient needs, and development of the local community services plan.

VII. Requirements of Operations

7.1 A home health agency must comply with all applicable state and federal policies, guidelines, laws and regulations. In the event that state and federal regulations differ, the more stringent regulation will apply.

7.2 A home health agency must conduct business and ensure delivery of services in compliance with the Americans with Disabilities Act.

7.3 A home health agency must not discriminate based on age, sex, race, sexual orientation or gender identity, country of origin, disability, source of payment, geography, or any other basis specified by law.

7.4 Each home health agency must engage in local and state planning and needs assessments, as directed by State and federal law, which may include participating in the development of the Health Resource Allocation Plan published pursuant to 18 V.S.A. § 9405 and the community health needs assessment conducted in accordance with 26 U.S.C. § 501(r)(3).

7.5 A home health agency must not employ or have a contract with any worker who has a substantiated record of abuse, neglect or exploitation of a child as determined by the Department for Children and Families or a substantiated record of abuse, neglect, or exploitation of a vulnerable adult as determined by the Department. A home health agency must conduct background checks, in accordance with the Department's background check policy, on all employees, independent contractors and volunteers that provide direct care to its patients.

7.6 A home health agency must ensure that staff, services and necessary supplies are available to meet the needs of its patients and that there are established contingency plans in the event of unexpected shortages of scheduled staff or supplies, or disruption in scheduled services.

7.7 A home health agency must develop, maintain, enforce and, upon request, provide to the Department policies and procedures concerning, but not limited to:

(a) Admission, transfer, reduction in services and discharge of patients;

(b) Medical supervision and plans of care;

(c) Emergency care;

(d) Patient records and other patient information, including, but not limited to, confidentiality, use, retention, protection, storage, disposition and disclosure;

(e) Personnel, including, but not limited to, qualifications, credential verification, staff orientation, training and evaluation, and, as applicable, policies pertaining to students and volunteers;

(f) Quality improvement and program improvement plans;

(g) Handling complaints and grievances;

(h) Use of electronic records addressing data integrity, confidentiality, security, authentication, non-repudiation, encryption, as warranted, and ability to be audited, as appropriate to the system and type(s) of information;

(i) Supervision of licensed and unlicensed personnel; and

(j) Advance directives.

7.8 A home health agency must develop and maintain an emergency management plan describing how it will continue to provide services or arrange for the provision of services (including, but not limited to, crisis response) for its patients in times of emergency, crisis or disaster. The plan must identify how the home health agency will address individual patient needs in the event of an unexpected, temporary disruption of services resulting from the emergency, crisis or disaster. A home health agency must make its emergency management plan available to the Department upon request.

7.9 A home health agency must develop and maintain a technological infrastructure that enables the home health agency to collect information, submit data, conduct needs assessments of patients in its designated area, and perform other required functions in a cost-effective manner.

7.10 A home health agency must have written contracts for clinical or direct care services provided on behalf of the home health agency by other home

health agencies, independent contractors or sub-contractors. The contracts must include:

(a) Names and signatures of parties to the agreement;

(b) Contract term;

(c) Specifications of work to be performed;

(d) Each party's responsibilities, functions and objectives during the contract term;

(e) Payment provisions;

(f) Business Associate Agreement, when applicable;

(g) Statement that the home health agency will retain administrative responsibility for services rendered, including, but not limited to, subcontracted services;

(h) Requirement that services will be provided in accordance with these regulations and that personnel providing services will meet licensing, training and experience requirements and will be supervised in accordance with these rules; and

(i) Requirement that the other party to a contract (i.e., home health agency, independent contractor or subcontractor) will provide the home health agency with written documentation regarding the amount and type(s) of services provided.

VIII. Required Functions and Administration

8.1 A home health agency must:

(a) Provide high quality, comprehensive services that are responsive to the population it serves; and

(b) Monitor the services delivered by its contracted service providers.

8.2 A home health agency must provide or arrange for the provision of all designated services to all eligible patients within its designated service area and to all eligible patients accepted onto service based on referrals from other designated agencies, subject to ability to accept referrals.

8.3 When a home health agency determines that it is unable to provide services to an eligible patient, the agency must provide information regarding

alternative providers that may be able to serve the individual. The home health agency must facilitate a referral to the alternative provider(s) unless the individual objects to the referral, there is no alternative provider that can serve the individual, or the necessary funding for the service(s) is unavailable. In the event the home health agency determines that it cannot provide or arrange for the provision of designated services, the home health agency must provide notice to the individual as required below in Section 15.5. In no event will a home health agency be required to provide a service where it cannot meet the patient's needs.

8.4 A home health agency must develop a fee schedule which must be provided upon request to all patients or their patient representative and to the public.

8.5 A home health agency must provide each of its participants in the Global Commitment to Health Section 1115 Demonstration Waiver Choices for Care program written notice of their right to contact and receive assistance from the State Long-Term Care Ombudsman. The notice must include the address and telephone number for the State and Regional Long-Term Care Ombudsman.

8.6 A home health agency must ensure that the State Long-Term Care Ombudsman or Office of the Health Care Advocate, or representatives of either or both offices, have:

(a) Access to review the patient records of an individual receiving home health services if:

(1) The patient or the patient representative consents; or

(2) The patient is unable to consent to the review and has no patient representative.

(b) Access to review the patient records of an individual receiving home health services as is necessary to investigate a complaint by, or on behalf of, a patient if:

(1) The patient representative refuses to give the permission;

(2) The State Long-Term Care Ombudsman, the Office of the Health Care Advocate, or the representative of either, is authorized by state and federal regulations to access the patient records; and

(3) The Regional Long-Term Care Ombudsman has obtained the approval of the State Long-Term Care Ombudsman, if applicable.

8.7 A home health agency, as a mandatory reporter, must report or cause a

report to be made in accordance with the provisions of 33 V.S.A. § 6903 and 33 V.S.A. § 6904 when it knows of or has received information of abuse, neglect or exploitation of a vulnerable adult, or when it has reason to suspect that a vulnerable adult has been abused, neglected, or exploited. The report must be made within 48 hours.

8.8 If a member of a home health agency staff qualifies as a mandatory reporter pursuant to 33 V.S.A. § 4913, the staff member must report to the Department for Children and Families within 24 hours of when it reasonably suspects a child is being abused, neglected, or exploited, in accordance with 33 V.S.A. Chapter 49.

8.9 A home health agency shall report critical incidents involving its patients to the Division of Licensing and Protection (DLP) Survey and Certification Unit by the next business day after it learns of the incident. Verbal reports shall be followed by written reports that summarize the incident.

8.10 A home health agency must cooperate and collaborate with Vermont Emergency Management Services ("EMS") personnel in its designated service area, as needed.

8.11 A home health agency must:

(a) Monitor and submit reports as requested by the Department regarding the provision of services, including, but not limited to, costs, outcomes, service accessibility and service delivery;

(b) Submit reports as requested by the Department regarding quality assurance, quality improvement, and outcome activities; and

(c) Protect confidentiality of its patient information when data are transferred by ensuring that the method of transferring the information is in compliance with state and federal laws and regulations.

8.12 A home health agency must establish mechanisms for the collection of data to be reported on an annual basis to the Department. Data to be collected and reported must include, but not be limited to, the following information:

(a) Complaints;

(b) Number of individuals on waiting lists for services;

(c) Number of individuals ineligible for services;

(d) Number of patients under the age of 65 currently receiving services

and the number that have received services since the last reporting cycle;

(e) Number of patients 65 years of age and older currently receiving services and the number that have received services since the last reporting cycle;

(f) Total number of visits and visiting hours provided to patients;

(g) Charitable and subsidized programs and services available through the home health agency for uninsured or low-income persons; and

(h) Other quality indicators or data deemed relevant by the Commissioner to monitor and evaluate access to, and the cost and quality of, home health services provided by each home health agency.

8.13 The home health agency must provide the Department, at the Department's request, with the results of patient surveys, data from federal and state surveys, scoring by national accrediting organizations, audited annual financial statements and annual cost reports. The home health agency must provide the results to the Department within ten (10) business days of its receipt of the Department's request.

IX. Fiscal Management

9.1 A home health agency must have fiscal management practices that demonstrate cost efficiency and cost controls and that include, at a minimum, the following:

(a) The ability to meet payroll and pay bills in a timely fashion;

(b) Reasonable efforts to collect all fees from individuals and third-party payers;

(c) Financial records and accounting practices that are maintained in accordance with generally accepted accounting principles; and

(d) Insurance coverage for fire, professional liability, general liability, and directors/officers' liability.

9.2 A home health agency must provide the Department with sufficient financial detail about home health agency services for purposes of collaborating with the Department to analyze data, costs and efficiencies of home health agency services paid for by the State.

9.3 A home health agency must disclose to the Department the information required in its application, as reflected in Section 4.5 above, at the time of the home health agency's initial request for designation, at the time of every survey, and at the time of any change in ownership or management.

X. Petitions to Commissioner

10.1 A home health agency may petition the Commissioner to cease providing [a] designated service(s), with 90 calendar days' notice, when an agency can demonstrate that financial losses from the home health service threaten the continued operation of the home health agency, disregarding private donations and municipal and town funds.

10.2 A home health agency experiencing financial distress may petition the Commissioner for temporary financial relief. The Commissioner, in his or her discretion, and if funds are available, may grant such temporary financial relief after a review of the home health agency's financial status. The temporary financial relief will be based upon a plan to correct the issues that led to the home health agency's financial distress. The plan of correction must be developed by the home health agency and approved by the Department before any financial assistance is provided.

XI. Skilled Services

11.1 A home health agency must furnish skilled services according to the Medicare Conditions of Participation (CoPs) and in accordance with the patient's plan of care. The Medicare HHA CoPs do not apply to those individuals who receive only unskilled services.

XII. Shared Service Agreements and Referrals

12.1 A home health agency may enter into shared services agreements with other home health agencies to provide or arrange for the provision of home health services that it would otherwise not offer, or to provide services more efficiently or effectively.

12.2 Prior to the implementation of a shared service agreement, a home health agency must submit the proposed agreement in writing to the Commissioner for approval.

12.3 The Commissioner will have 60 calendar days from receipt of a shared services agreement within which to provide written approval or disapproval of the plan to the home health agencies proposing the agreement.

12.4 A home health agency must initiate communication with each patient by

the close of the next business day after the receipt of a physician order, or as specified by the physician order.

XIII. Change in Status: Ownership, Location or Discontinuation of Operation or Designated Services

13.1 When a change of ownership or location is planned, the home health agency is required to file a new application for designation at least 90 calendar days prior to the proposed date of the change.

13.2 A home health agency must apply for a new CON when greater than 50% ownership interest in the home health agency is transferred or conveyed and must provide the Department with a copy of the newly issued CON.

13.3 A home health agency that intends to discontinue all or part of its operation or designated services or intends to transfer ownership or change the location or address of the agency in such a way as to necessitate the discharge of patients, must provide written notice as outlined below. The home health agency is responsible for ensuring that all patients are discharged in a safe and orderly manner.

(a) General Notice Requirements

(1) At least 90 calendar days prior to the proposed date of any such change, a home health agency must provide written notice to the Department, the Office of the Health Care Advocate and the State Long-Term Care Ombudsman.

(2) At least 60 calendar days prior to the proposed date of any such change a home health agency must place a legal notice in local area newspapers. The notice must include the date of the intended change, and, if the change involves closure of a program or the home health agency, the date upon which the home health agency will no longer accept patients.

(3) At least 45 calendar days prior to the proposed date of any such change, a home health agency must provide a detailed written plan to the Department, the Office of the Health Care Advocate and the State Long-Term Care Ombudsman describing how the home health agency intends to provide for the safe and orderly transfer to other service providers or discontinuation of services for its patients. The plan must include:

(i) Assurances that adequate staff and patient care will be provided during the transfers;

(ii) Arrangements to ensure the orderly transfer of patients to another service provider(s); and

(iii) A protocol for disposition of patient files and home health agency records.

(4) Upon request, the home health agency must provide to the Department any additional information related to the transfer to other service providers or the discontinuation of designated services or its operations plan, as well as follow-up reports regarding specific placement action.

(b) Patient Notice Requirements.

(1) At least 60 calendar days prior to the proposed date of any change that would necessitate discontinuation of a designated service or transfer to another service provider, a home health agency must provide written notice to all patients or their patient representatives receiving the designated service(s).

(2) The notice must be provided on forms approved by the Department for non-Medicare services. The notice must include:

(i) The reason for the discontinuation of the designated service(s) or transfer to another service provider;

(ii) The date the designated service(s) will be discontinued or the transfer to another service provider will occur; and

(iii) Information about how to contact the Office of the Health Care Advocate and State Long-Term Care Ombudsman.

(3) At least 30 calendar days prior to closure of the home health agency or discontinuation of a designated service, a home health agency must provide to each patient receiving the designated service an individualized plan to ensure continuity of care.

(c) In the event of a home health agency closure or discontinuation of a service(s), all home health agency rules and regulations will remain fully applicable until all patients have been transferred to other service providers.

(d) When a home health agency intends to make a change (e.g., admission or retention policy, ownership, or location of the agency) in such a way that does not necessitate the discharge of patients or transfer

to another service provider, the home health agency must provide written notice to the Department and to the patient(s) at least thirty (30) days prior to such a change.

XIV. Notice to Patients and Public Regarding Suspension/Revocation/Non-Renewal of Designation Status

14.1 If a designation is suspended, revoked, or not renewed, a home health agency must notify all its patients in writing about the action within 5 days of receipt of the notification of a suspension, revocation or non-renewal. The notice must include the date of the suspension, revocation or non-renewal and, if the change involves closure of a program or the home health agency, the date upon which the home health agency will no longer accept patients and the effective date of closure, if applicable.

14.2 If a designation is suspended, revoked, or not renewed, a home health agency must advise the public of such action. The public notice must be in the form of a paid legal notice in the local area newspaper(s), published within 15 calendar days following receipt by the home health agency of written notification of the suspension, revocation or non-renewal of the designation.

XV. Admissions, Denials, Reduction of Services, Discharge of Patients and Notice

15.1 A home health agency must develop and implement policies and procedures that set forth the steps that the home health agency will follow regarding:

(a) denial of an admission for designated home health services (as used in this Section, a "denial");

(b) reduction of services for patients; and

(c) discharge of patients.

15.2 Discharge planning for patients must be initiated at the time of admission of a patient to home health services and must be provided as part of the ongoing assessment of a patient's continuing care needs and in accordance with expected patient care outcomes.

15.3 When a home health agency denies an application for admission, or reduces the services being provided to an existing patient or discharges an existing patient from services pursuant to 15.4(a), 15.4(b) or 15.4(c), the home health agency must provide a verbal notice followed by a written notice, to the patient and patient representative as applicable. Notices must be accessible and written in language that is understandable to a layperson.

The home health agency must provide verbal notice to the patient and patient representative, if applicable, either in person or by telephone. The home health agency must provide written notice by hand-delivery or by mailing the notice to their last known mailing addresses.

15.4 A home health agency may reduce the designated services being provided to an existing patient or discharge an existing patient from services only as provided for in this subsection:

(a) A home health agency may reduce the designated services being provided to an existing patient or discharge an existing patient from services with verbal and written notice as soon as practicable when one (1) or more of the following occurs:

(i) The patient has requested that the home health services be reduced or that the patient be discharged from services;

(ii) The patient has moved out of the home health agency's designated service area;

(iii) The patient has chosen another provider, and arrangements have been made for the alternate provider to assume responsibility for the home health care needs of the patient; or

(iv) The patient is admitted to a hospice, hospital, nursing home, residential care home, or rehabilitation facility;

(b) A home health agency may reduce the designated services being provided to an existing patient or discharge an existing patient from services with written notice at least 2 business days before the reduction in or discharge from services when one (1) or more of the following occurs:

(i) Goals and treatment objectives have been met, and skilled services are no longer medically necessary as determined by the physician and reflected in the physician's orders;

(ii) The home health agency has been notified by the third-party payer, the patient or the case manager that the patient no longer meets the eligibility requirements for the services, or the services are no longer authorized or covered by the patient's health insurance plan; or

(iii) The home health agency has documented its unsuccessful efforts to obtain written orders for skilled services from the patient's physician.

(c) A home health agency may reduce the designated services being provided to an existing patient or discharge an existing patient from services with written notice at least 14 calendar days before the reduction in or discharge from services when one (1) or more of the following occurs:

(i) The patient has failed to pay for services for which he or she is responsible;

(ii) After attempting to resolve the situation, the home health agency determines and documents that the patient's needs cannot be adequately met in the home by the home health agency; or

(iii) The patient, primary caregiver or other person in the home has exhibited behavior, including, but not limited to, physical abuse, sexual harassment, verbal threats or abuse, or threatening behavior that poses a safety risk to agency staff.

(d) A home health agency may reduce services or discharge a patient immediately and without advance notice if the patient, primary caregiver or other person in the home has exhibited behavior which presents an imminent risk of harm to agency staff.

(e) In emergency situations, when the home health agency cannot reasonably provide advance notice, the agency must provide verbal and written notice as soon as practicable.

15.5 The written notice of a denial of admission to home health services, a reduction in existing home health services, or a discharge from services, must include the following information:

(1) The specific reason(s) for the denial, reduction of or discharge from services;

(2) The effective date of the decision to reduce services or discharge a patient from services;

(3) Specific information about *how* to appeal, in accordance with Section XXII. of these regulations;

(4) Contact information for the Office of the Health Care Advocate and the Office of the State Long-Term Care Ombudsman;

(5) A statement that, while an appeal is pending, the patient may request to continue existing services only, or a statement that no services are available for appeals of the denial of admission to

home health services; and

(6) A statement that a request for continuing services, if any, following a reduction in or discharge from services under circumstances listed in Section 15.4(c)(ii) or (iii), must be made to the Division of Licensing and Protection's State Survey Agency and must be made before the effective date of the intended action.

15.6 A home health agency must provide for the following when discharging a patient to protect the safety of staff pursuant to Section 15.4(c)(iii).

(a) When discharging a patient from services pursuant to Section 15.4(c)(iii) above, the home health agency must:

(1) notify the physician, if working under a physician's order, and the case manager, if applicable, of the reason for discharge (i.e., safety concerns);

(2) advise the patient and the patient representative, if applicable, verbally and in writing, that a discharge from services for safety reasons is being pursued, explaining the specific safety issue that is the cause of the discharge;

(3) demonstrate and document in the patient's medical record that a reasonable effort has been made to resolve the problem(s) presented by the patient's behavior or the situation that caused safety concerns; and

(4) document in the patient's record the problem(s) and efforts made to resolve the problem(s).

(b) When, based on the specific circumstances, there is an immediate need to reduce services or to discharge a patient from services due to an imminent risk of harm and the home health agency cannot reasonably provide advance notice, the home health agency need not comply with the requirements set forth in 15.5 and 15.10. Rather, the home health agency must adequately document the basis for its determination that an immediate need to discharge or reduce services existed. The determination as to an immediate need to discharge or reduce services must be based on an assessment by the home health agency that risk of harm to the home health agency staff providing the services is imminent. The home health agency must notify the physician, if working under a physician's order, and the case manager, if applicable, of the reason for discharge (i.e., safety concerns);

(c) The home health agency must provide verbal and written notice to the patient and the patient representative, if applicable, as soon as

practicable immediately following the determination to discharge from or reduce services based on an imminent risk of harm. The notification must explain:

(1) the description of the imminent risk of harm;

(2) the basis for the discharge from or reduction of services;

(3) the reason why advance notice was not given;

(4) the effective date of the reduction of services or discharge from services;

(5) what steps, if any, the patient may take to remediate the situation such that services may be restored;

(6) specific information about how to appeal, in accordance with Section XXII. of these rules, including, but not limited to, a statement that the patient may request that services currently in place continue while the appeal is pending, if applicable, and that continuing services are not available unless and until the imminent risk of harm has been remediated.

(7) Contact information for the Office of the Healthcare Advocate and the Office of the State Long-Term Care Ombudsman.

15.7 If an individual was previously discharged from service by a home health agency in accordance with 15.4(c)(iii) or 15.4(d), and the behavior or conditions causing the discharge cannot be reasonably mitigated or eliminated, a home health agency, upon receipt of a subsequent request to admit the individual, may:

(a) deny the new admission for service; or

(b) accept the admission but decline to send a home health agency employee to make a visit if the home health agency has reason to believe that the individual who exhibited behavior that resulted in the discharge is present in the home.

15.8 A home health agency is not required to enter into a home to determine if a risk can be mitigated or eliminated pursuant to Section 15.7; however, if a home health agency employee declines to enter the home, the home health agency must provide the patient verbal notice and, within 5 business days, written notice, detailing the reasons for its decision.

15.9 If a home health agency denies a new admission for service, pursuant to 15.7(a), it must provide written notice to the patient and the patient

representative, if applicable. The notice must include:

(a) The reason for the denial of service;

(b) Information about how to file a complaint in accordance with Section 17.16 of these regulations; and

(c) Contact information for the Office of the Health Care Advocate and the Office of the Long-Term Care Ombudsman.

15.10 When a home health agency determines that a patient will require continuing care after services are discontinued, the agency must arrange, with the patient's consent, or actively assist the patient with arranging for such services. The home health agency must document its efforts to arrange for, or assist the patient with arranging for, continued care in the patient's clinical record, and must provide sufficient clinical information to the receiving entity to assure continuity of care and services. The home health agency must educate the patient about how to obtain further care, treatment and services to meet his or her identified needs, if applicable.

15.11 A home health agency must follow the CMS regulations governing notices and appeal rights when the home health agency reduces Medicare covered services for a patient or discharges a patient receiving only Medicare-covered services.

15.12 When a home health agency discharges a patient from services for any of the circumstances specified in this section, the circumstances must be documented in the patient record.

15.13 In addition to the requirements of this section, in the event that a home health agency discontinues offering a service (other than a designated service) or ceases operation, notice must be provided in accordance with Section 13.3 above.

XVI. Patient Assessment and Plan of Care

16.1 All Medicare Certified Services must follow the Medicare CoPs for the patient assessment and development of the plan of care.

16.2 The patient assessment and plan of care regarding programs not covered by Medicare will follow the applicable program standards. In the absence of standards, the home health agency will respond to referrals in two business days.

16.3 A patient's plan of care must be person-centered, understandable to a layperson, and formatted in a form accessible to the patient and the patient

representative, if applicable.

16.4 A home health agency must ensure that services are furnished to the patient in accordance with the patient's plan of care.

16.5 A home health agency must respond in a timely manner to patient requests regarding his or her plan of care, including, but not limited to, requests for care conferences or changes in service. Home health agencies must respond as soon as practicable.

16.6 A home health agency must consider a patient's preferences for services and caregivers and must collaborate with the patient's other service providers, service agencies or service systems, if appropriate and requested by the patient.

XVII. Patient Rights

17.1 A patient has the right to receive a timely response to his or her request for services from the home health agency.

17.2 A patient has the right to be fully informed by the home health agency of all of his or her rights and responsibilities associated with the provision of care by the home health agency. A patient has the right to receive written notice from the home health agency of patient rights during the initial visit or before care is furnished or any time at the patient's request

17.3 A patient has the right to appropriate and professional care in accordance with appropriate standards of care.

17.4 A patient has a right to receive care and treatment free of maltreatment, including, but not limited to, abuse, neglect and exploitation.

17.5 A patient has the right to participate in care planning and in that care, to be informed by the home health agency in advance of changes in care and to be informed of the type of providers that will provide care and the frequency of visits.

17.6 A patient has the right to refuse treatment within the confines of the law and to be informed of the consequences of that action.

17.7 A patient has the right to be informed of his or her right to formulate advance directives.

17.8 A patient has the right to confidentiality of his or her protected health information and the right to review his or her patient record upon request.

17.9 A patient has the right to have his or her property and person respected

by the home health agency.

17.10 A patient has the right to be informed about how to contact the home health agency at all times.

17.11 A patient has the right to be informed by the home health agency of the telephone number for the toll-free home health hotline. The home health agency must inform the patient that the purpose of the hotline is to receive complaints or questions about local home health agencies.

17.12 A patient has the right to receive from the home health agency an admission packet that includes relevant information, including, but not limited to, the contact information for the Office of the Health Care Advocate or, if the patient receives services under the Global Commitment to Health 1115 Medicaid Waiver as a Choices for Care program participant, the State Long-Term Care Ombudsman.

17.13 A patient has the right to be fully informed of home health agency policies and charges for services, including, but not limited to, eligibility for third-party reimbursements. Before the care is initiated, the home health agency must inform the patient of:

(a) The extent to which payment may be expected from Medicare, Medicaid, any other federally funded program, or any State program or private insurance known to the home health agency; and

(b) The charges that may be the responsibility of the patient.

17.14 A patient has the right to voice grievances and request changes in services or staff without fear of retaliation or discrimination by the home health agency.

17.15 A patient has the right to appeal a notice of discharge from or reduction in home health agency services or a denial of admission to the home health agency and to receive information about the appeal process.

17.16 A patient has the right to file complaints with the Division of Licensing and Protection. If dissatisfied with the resolution of the complaint, the patient may ask for the decision to be reviewed by the Commissioner.

17.17 A patient has the right to review reports of state and federal surveys of the home health agency and the right to receive copies of the survey reports upon request to the Division of Licensing and Protection.

17.18 Any of the rights enumerated in this section may be exercised by an individual who has the legal authority (e.g., patient representative) to act on

behalf of the patient, when the patient lacks the capacity to exercise those rights.

XVIII. Quality Assurance and Improvement

18.1 A home health agency must establish an effective, ongoing, data-driven quality assessment and performance improvement program that reflects the full range of home health agency services, including, but not limited to, those services furnished under contract or other formal or informal arrangement. The program must:

(a) Include an ongoing measurable data collection system that tracks and focuses on indicators to improve patient outcomes and reduce errors;

(b) Measure, analyze, and track quality indicators, including, but not limited to, adverse patient events, existing or potential problems, and other performance indicators that assess quality, effectiveness and efficiency of agency services and operations;

(c) Identify changes that will lead to improvement;

(d) Implement quality improvement(s) and corrective action(s);

(e) Evaluate results of quality improvement(s) and correction action(s); and

(f) Assure systemic integration of successful quality improvement actions and corrective action(s).

18.2 The frequency and detail of data collection must be specified by the governing body or board of the home health agency and must include detail and data as needed and specified by the Department.

18.3 A home health agency must participate in the Department's Quality Review processes and monitoring activities. The home health agency must respond in a timely and effective manner to recommendations made in the Department reviews and/or other monitoring reports.

18.4 A home health agency must establish program priorities for performance improvement activities that:

(a) Focus on high risk, high-volume, or problem prone areas;

(b) Consider the incidence, prevalence, and severity of problems in

those areas;

(c) Focus on practices that affect patient safety; and

(d) Identify trends in tracked errors and adverse patient events.

18.5 A home health agency must obtain and monitor patient and family satisfaction, keep written records of all of its monitoring efforts, and document the use of this information through quality improvement activities. These written records must be made available to the Department upon request.

18.6 A home health agency's quality assurance and improvement activities must include, but not be limited to, involvement by direct care staff in the identification and planning of quality improvement activities.

XIX. Survey and Review

19.1 The Department will survey a home health agency prior to designation and at any other time it considers a survey necessary to determine if an agency is in compliance with these regulations.

19.2 Regardless of the term of designation, the Department will monitor a home health agency for continued compliance with applicable laws and rules on at least an annual basis, except that surveys, at the Department's discretion, need not be conducted during a year when a Medicare certification survey is performed. Surveys may be conducted more frequently in any of the following circumstances:

(a) Change of ownership;

(b) Receipt of complaints; or

(c) Other circumstances that could have an impact on the home health agency's ability to meet the needs of the patients in the designated service area.

19.3 The Department will have access to the home health agency at all times, with or without notice, to conduct investigations. An application for designation, whether initial or renewal, will constitute permission for entry into, and survey of, a home health agency by representatives of the Department during the pendency of the application and, if designated, during the period of designation.

19.4 The Department will investigate whenever it has reason to believe a violation of the law or regulations by the home health agency has occurred.

Investigations will be conducted by the Department and may be conducted at any place or include any person the Department believes possesses information relevant to its regulatory responsibility and authority.

19.5 After each survey or complaint investigation, the Department will hold an exit conference with the Chief Executive Officer or Executive Director of the home health agency. The exit conference will include an oral summary of the Department's findings and, if regulatory violations were found, a notice that the home health agency must develop and submit an acceptable plan of correction. The Department will post the survey statements on the Department's website.

19.6 The Department will prepare a written report that summarizes the results of the survey. The report will be sent to the home health agency upon completion. The report will include the following:

(a) A description of each condition that constitutes a violation;

(b) Each rule or statutory provision alleged to have been violated;

(c) The date by which the home health agency must return a plan of correction for the alleged violation(s);

(d) The date by which each violation must be corrected;

(e) Sanctions the Department may impose for failure to correct the violation or failure to provide proof of correction by the date specified;

(f) The right to apply for a variance;

(g) The right to an informal review; and

(h) The right to appeal the determination of violation to the Commissioner within 15 calendar days of the date of the notice of violation.

19.7 If a home health agency receives a notice of violation(s) from the Department, it must submit a written plan of correction to the Department within ten (10) business days of the date of the notice of violation.

(a) A home health agency's plan of correction must describe how the agency intends to correct each violation, the expected date of completion, how the plan will be monitored and the person responsible for overseeing the plan of correction.

(b) A home health agency must post statements of deficiencies in a location readily visible to patients and to the public on those premises

where the home health agency's business operations are conducted.

(c) The Department may accept the plan of correction as written or may require modification.

19.8 If, as a result of an investigation or survey, the Department determines that a home care business is operating without designation and meets the definition of a home health agency, written notice of the violation will be prepared and provided to the business.

19.9 Patients, patient representatives and the public will have the right to review current and past state and federal survey and inspection reports of the home health agency, and, upon request, to receive a copy of any such report from the home health agency. Copies of reports must be available for review during normal business hours at one location in the home health agency. The home health agency may charge an amount for hard copies of the reports consistent with state record copying costs. The home health agency must provide electronic copies, if requested, at no cost.

XX. Enforcement

20.1 The Department may take immediate enforcement action when necessary to eliminate a condition at a home health agency or a condition that exists through the provision of its services that can reasonably be expected to cause death or serious harm to patients' or staff's health or safety. If the Department takes immediate enforcement action, it will explain its actions and the reasons for those actions in the notice of violation.

20.2 The Department may require a home health agency to take corrective action to eliminate a violation of a rule or statute and provide the Department with proof of correction of the violation(s) within a period of time specified by the Department.

(a) If the Department does require corrective action, the Department may, within the limits of resources available to it, provide technical assistance to the home health agency to enable it to comply with the statutory and regulatory requirements;

(b) If a home health agency has not corrected the violation by the time specified, the Department may take such further action as it deems appropriate in accordance with these regulations and governing federal and state law.

20.3 The Department may assess administrative penalties against a home health agency for failure to correct a violation or failure to comply with a plan

of corrective action. The Department will determine the primary purpose of the rule or provision at issue and may assess administrative penalties in accordance with the daily financial penalties set forth below:

(a) Up to $500.00 for each day a violation remains uncorrected if the rule or provision violated was adopted primarily for administrative purposes;

(b) Up to $800.00 for each day a violation remains uncorrected if the rule or provision violated was adopted primarily to protect the welfare or the rights of patients;

(c) Up to $1000.00 for each day a violation remains uncorrected if the rule or provision violated was adopted primarily to protect the health or safety of patients;

(d) For purposes of imposing administrative penalties under this subsection, a violation will be deemed to have first occurred as of the date of the initial notice of violation.

20.4 The Department may suspend, revoke, modify or refuse to renew a designation of a home health agency on any of the following grounds:

(a) Violation by a home health agency of any of the provisions of the law or regulations;

(b) For committing, permitting, aiding or abetting any illegal practices in the operation of the home health agency or for conduct or practices detrimental to the health, safety, or welfare of patients to whom home health services are provided.

(c) Financial incapacity of a home health agency to provide or arrange for adequate care and services; or

(d) Failure by a home health agency to comply with a final decision or action of the Department.

20.5 The Department may suspend admissions to a home health agency for a violation that may directly impair the health, safety or rights of patients, or for operating without designation.

20.6 The Department, the attorney general, or a patient may bring an action for injunctive relief against a home health agency in accordance with the Rules of Civil Procedure to enjoin any act or omission which constitutes a violation of the law or regulation. Notice of such action will be given to the Office of the Health Care Advocate and, if applicable, the State Long-Term Care

Ombudsman.

20.7 The Department, the attorney general, or a patient may bring an action in accordance with the Rules of Civil Procedure for the appointment of a receiver for a home health agency, if there are grounds to support suspension, revocation, modification or refusal to renew the agency's designation. Notice of such action will be given to the Office of the Health Care Advocate and, if applicable, the State Long-Term Care Ombudsman.

20.8 The Department may enforce a final order for appointment of a receiver by filing a civil action in the superior court in the county in which the home health agency is located or in Washington Superior Court.

20.9 The remedies provided for violations of the law or regulations are cumulative.

20.10 A person or home health agency that knowingly violates the designation or confidentiality requirements of these rules may be subject to criminal penalties pursuant to 33 V.S.A. §7116.

20.11 Upon notice of suspension or revocation of a designation, the home health agency must immediately surrender the certificate of designation to the Department.

20.12 The Department, working in collaboration with a home health agency, may appoint a temporary manager to operate a home health agency as a substitute manager. The temporary manager will have the authority to hire, terminate or reassign staff, obligate funds, alter agency policies and procedures and manage the provision of home health services to correct operational deficiencies.

(a) A temporary manager may be appointed in the following circumstances:

(1) When the home health agency intends to close, but has not arranged for the orderly transfer of its patients at least 60 calendar days prior to closure;

(2) When an emergency exists in a home health agency which threatens the health, safety or welfare of its patients; or

(3) When a home health agency is in substantial or habitual violation of the standards of health, safety or patient care established under state or federal regulations to the detriment of the welfare of the patients.

(b) A temporary manager must be qualified based on experience and education to oversee the correction of operational deficiencies and must not:

(1) Have been found guilty of misconduct by any licensing board or professional society in any state;

(2) Have, nor may a member of his or her immediate family have, a financial ownership interest in the home health agency, and;

(3) Currently serve or, within the past 2 years have served as a member of the staff of the home health agency.

(c) A temporary manager's salary must be paid directly by the home health agency and must be at least equivalent to the sum of the following:

(1) The prevailing salary paid by providers for positions of this type in the home health agency's designated service area;

(2) Additional costs that would have reasonably been incurred by the home health agency if such person had been in an employment relationship; and

(3) Any other costs incurred by such a person in furnishing services under such an arrangement or as otherwise set by the Department.

(d) A temporary manager's salary may exceed the amount specified in subsection (c) above if the Department is otherwise unable to attract a qualified temporary manager within the salary requirements listed in (c) above.

(e) If a home health agency fails to relinquish authority to the temporary manager as described in this section, the Department will terminate the designation.

(f) A home health agency's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

(g) Temporary management will end when a home health agency meets the conditions specified in this section and receives approval from the Commissioner or when it is determined that the home health agency will no longer be designated.

XXI. Complaints Received by Home Health Agencies Regarding Staff, Management or Other Service Providers

21.1 A home health agency must investigate complaints regarding its staff or management, or anyone furnishing services or supplies on behalf of the home health agency. The complaints may be submitted to the home health agency by patients, a patient's family, a patient representative, the State Long-Term Care Ombudsman or the Office of the Health Care Advocate. The home health agency must furnish patients with the toll-free telephone number for the Home Health Hotline to report complaints.

21.2 The home health agency must respond to all complaints, whether received orally or in writing, within two (2) business days of receiving the complaint(s).

21.3 A home health agency must keep a log of all complaints. The log must include the date of the complaint(s), the name of the complainant(s), the subject of the complaint(s), the name of the person assigned to investigate the complaint, and the date and resolution of the complaint(s).

21.4 A home health agency must report to the Division of Licensing and Protection any quality of care or service-related complaint not resolved to the satisfaction of the patient within 8 business days of the home health agency receiving the complaint.

21.5 When a quality of care or service-related complaint is not resolved to the satisfaction of the patient within five (5) business days, a home health agency must notify the complainant in writing of the right to request assistance from the Office of the Health Care Advocate or, if applicable, the State Long-Term Ombudsman and provide the contact information for those offices. If both the home health agency and the patient are actively seeking resolution but the issue(s) is(are) not resolved within 30 calendar days of receiving the complaint, the home health agency must notify the patient in writing that he or she may complain to the Department at that time.

XXII. Patient Appeals

22.1 A patient or the patient representative, if applicable, who is notified by CMS of a reduction in or a discharge from Medicare services must follow the appeals process outlined in the written notification from CMS.

22.2 A patient or the patient representative, if applicable, who is notified by Medicaid or another third-party payer of a reduction in or a discharge from services must follow the appeals process outlined by the payer.

22.3 A patient or the patient representative, if applicable, who is notified by a home health agency of its denial of an application for admission or its

reduction of, or discharge from, services, and who plans to appeal the home health agency's decision must follow the appeals process outlined in this section of the rules.

22.4 To appeal the decision of the home health agency to deny admission to services, or reduce or discharge a patient from services, the patient or the patient representative, if applicable, must, within 30 calendar days of the date of the written notice of decision from the home health agency, contact the Division of Licensing and Protection's State Survey Agency to appeal the home health agency's decision to the Director of the State Survey Agency.

22.5 The Division of Licensing and Protection's State Survey Agency will issue its decision within 30 calendar days of its receipt of the request for appeal. The State Survey Agency may extend the time for resolving an appeal by up to 14 calendar days upon request of the patient or patient representative, or upon showing there is a need for additional information and how the delay is in the best interest of the patient.

22.6 Copies of all materials submitted to the Division of Licensing and Protection's State Survey Agency by the home health agency will be available to the patient or the patient representative, if applicable, upon request.

22.7 The written decision rendered by the Director of the State Survey Agency at the Division of Licensing and Protection will be sent to the patient or patient representative, if applicable, and the home health agency, and will include the reason(s) for the decision and a statement that if the decision is not favorable to the patient, the decision may be appealed to the Human Services Board, with information about how to request a fair hearing, and the timeline for requesting an appeal to the Human Services Board. The notice will include contact information for the Human Service Board and inform the patient or the patient representative, if applicable, that a request for a fair hearing may be made either orally or in writing and must be directed to the Human Services Board.

22.8 Upon the request of a patient or patient representative, a home health agency must provide or arrange for continuing services for the patient during the pendency of the patient's appeal to the Human Services Board concerning a reduction of or discharge from services if the payment source provides for continuing services. The home health agency must document its efforts regarding patients' continuing services in the patient's clinical record. Services will not be provided or continued when an immediate need exists to end services due to an imminent risk of harm to the home health agency staff providing the services and the imminent risk of harm has been documented in the patient record and other relevant home health agency records, unless and until the imminent risk of harm has been remediated.

22.9 There is no right to an appeal if the sole issue is a state or federal law requiring an automatic change adversely affecting some or all patients. A patient retains the right to appeal the application of the law to the facts of an individual's case.

XXIII. Home Health Agency Appeals

23.1 A home health agency aggrieved by a notice of violation may file a request for an informal review with the State Survey Agency. The request must be made to the State Survey Agency within 10 business days of receipt of the notice of violation.

23.2 A home health agency applying for re-designation or any person, partnership, association or corporation applying for designation, may appeal the Department's decision to take any of the following actions with regard to designation:

(a) The issuance of a conditional designation;

(b) The amendment or modification of the terms of a designation;

(c) The refusal to grant or renew a designation;

(d) The refusal to grant a conditional designation; or

(e) A notice of violation.

23.3 A home health agency may request a Commissioner's hearing regarding any action by the Department set forth in Section 23.2 above.

(a) The request for a Commissioner's hearing must be in writing and must be made within 15 calendar days of the date of the decision or action notice of the Department.

(b) The request for hearing must be accompanied by a clear statement of the basis for the request.

(c) Issues not raised in the request for hearing may not be raised later in the proceeding or in any subsequent proceeding arising from the same action of the Department.

(d) Proceedings under this section are not subject to the requirements of 3 V.S.A. chapter 25.

23.4 A home health agency aggrieved by a final decision by the Commissioner may file a request for a fair hearing before the Human Services Board.

(a) A request for a fair hearing may be initiated by calling the Human Services Board or by filing a written request for a fair hearing with the Human Services Board within 30 calendar days of the date of the Commissioner's decision.

(b) No appeal may be taken on any issue that was not raised previously in the request for hearing.

XXIV. Patient Records

24.1 A home health agency must maintain a patient record for every patient receiving home health services from the agency. The patient record must include pertinent and comprehensive information regarding the patient's history and current findings as to the patient's condition(s) and status, in accordance with accepted professional standards and in accordance with the requirements of the program under which the patient is served by the home health agency. A home health agency must ensure that whenever a patient's advance directive, including a DNR or COLST, is provided to the agency, a copy is included in the patient record. If the home health agency is taking direction from an individual who claims to be a patient's power of attorney or guardian, the home health agency must have a copy of the power of attorney or guardianship documentation in the patient record.

24.2 A home health agency must maintain the confidentiality of all patient records, including, but not limited to, personal and medical information contained in the patient records, and must safeguard patient record information against loss or unauthorized use.

24.3 A home health agency must develop written policies and procedures governing the use and destruction of patient records and the release of information from patient records to a patient or other authorized individual or entity in accordance with state and federal law.

(a) The home health agency must obtain the patient's or the patient representative's written consent prior to release of information from the patient record, excepting access to the patient record by authorized employees of the home health agency, or in the case of a patient transfer to another provider or as permitted by law.

(b) The home health agency's policy pertaining to the release of information from patient records must establish a reasonable cost, consistent with state record-copying costs, for the provision of copies of patient records.

24.4 A home health agency must retain patient records for ten (10) years after the month the cost report to which the records apply is filed with the fiscal intermediary, unless state or federal law stipulates a longer period of time. A

home health agency must arrange for the retention of the records, in accordance with applicable federal and state laws and regulations, even if the home health agency discontinues operations.

24.5 If a patient is transferred to a health care facility, the home health agency must send a copy of the patient record or patient health abstract with the patient.

24.6 A home health agency must ensure that a patient's advance directive, including a DNR or COLST, is accessible to authorized individuals and that home health agency staff are familiar with the patient's wishes and with the requirement that the patient's wishes and preferences be honored.

XXV. Unlicensed Caregiver Services

25.1 If a home health agency provides or arranges for unlicensed caregiver services, those services must be provided pursuant to a patient's plan of care in accordance with state and federal program standards and must include, but not be limited to, personal care services and/or homemaker services.

25.2 A home health agency must ensure the competency of the unlicensed caregivers it employs, train those caregivers to perform specific tasks for specific patients, and ensure that the caregivers are appropriately supervised by a qualified supervisor, as provided for in the agency's policies and job descriptions.

The Vermont Statutes Online

The Statutes below include the actions of the 2025 session of the General Assembly.

NOTE: The Vermont Statutes Online is an unofficial copy of the Vermont Statutes Annotated that is provided as a convenience.

Title 1 : General Provisions

Chapter 005 : Common Law; General Rights

Subchapter 003 : ACCESS TO PUBLIC RECORDS

(Cite as: 1 V.S.A. § 317)

§ 317. Definitions; public agency; public records and documents; exemptions

(a) As used in this subchapter:

(1) "Business day" means a day that a public agency is open to provide services.

(2) "Public agency" or "agency" means any agency, board, department, commission, committee, branch, instrumentality, or authority of the State or any agency, board, committee, department, branch, instrumentality, commission, or authority of any political subdivision of the State.

(b) As used in this subchapter, "public record" or "public document" means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired in the course of public agency business. Individual salaries and benefits of and salary schedules relating to elected or appointed officials and employees of public agencies shall not be exempt from public inspection and copying.

(c) The following public records are exempt from public inspection and copying:

(1) Records that by law are designated confidential or by a similar term.

(2) Records that by law may only be disclosed to specifically designated persons.

(3) Records that, if made public pursuant to this subchapter, would cause the custodian to violate duly adopted standards of ethics or conduct for any profession regulated by the State.

(4) Records that, if made public pursuant to this subchapter, would cause the custodian to violate any statutory or common law privilege other than the common law deliberative process privilege as it applies to the General Assembly and the Executive Branch agencies of the State of Vermont.

(5)(A) Records dealing with the detection and investigation of crime, but only to the extent that the production of such records:

(i) could reasonably be expected to interfere with enforcement proceedings;

(ii) would deprive a person of a right to a fair trial or an impartial adjudication;

(iii) could reasonably be expected to constitute an unwarranted invasion of personal privacy;

(iv) could reasonably be expected to disclose the identity of a confidential source, including a state, local, or foreign agency or authority or any private institution that furnished information on a confidential basis, and, in the case of a record or information compiled by criminal law enforcement authority in the course of a criminal investigation or by an agency conducting a lawful national security intelligence investigation, information furnished by a confidential source;

(v) would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecution if such disclosure could reasonably be expected to risk circumvention of the law;

(vi) could reasonably be expected to endanger the life or physical safety of any individual.

(B) Notwithstanding subdivision (A) of this subdivision (5), records relating to management and direction of a law enforcement agency; records reflecting the initial arrest of a person, including any ticket, citation, or complaint issued for a traffic violation, as that term is defined in 23 V.S.A. § 2302; and records reflecting the charge of a person shall be public.

(C) It is the intent of the General Assembly that in construing subdivision (A) of this subdivision (5), the courts of this State will be guided by the construction of similar terms contained in 5 U.S.C. § 552(b)(7) (Freedom of Information Act) by the courts of the United States.

(D) It is the intent of the General Assembly that, consistent with the manner in which courts have interpreted subdivision (A) of this subdivision (5), a public agency shall not reveal information that could be used to facilitate the commission of a crime or the identity of a private individual who is a witness to or victim of a crime, unless withholding the identity or information would conceal government wrongdoing. A record shall not be withheld in its entirety because it contains identities or information that have been redacted pursuant to this subdivision (D).

(6) A tax return and related documents, correspondence, and certain types of substantiating forms that include the same type of information as in the tax return itself filed with or maintained by the Vermont Department of Taxes or submitted by a person

to any public agency in connection with agency business.

(7) Personal documents relating to an individual, including information in any files maintained to hire, evaluate, promote, or discipline any employee of a public agency; information in any files relating to personal finances; medical or psychological facts concerning any individual or corporation; provided, however, that all information in personnel files of an individual employee of any public agency shall be made available to that individual employee or his or her designated representative.

(8) Test questions, scoring keys, and other examination instruments or data used to administer a license, employment, or academic examination.

(9) Trade secrets, meaning confidential business records or information, including any formulae, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that is not patented, which a commercial concern makes efforts that are reasonable under the circumstances to keep secret, and that gives its user or owner an opportunity to obtain business advantage over competitors who do not know it or use it, except that the disclosures required by 18 V.S.A. § 4632 are not exempt under this subdivision.

(10) Lists of names compiled or obtained by a public agency when disclosure would violate a person's right to privacy or produce public or private gain; provided, however, that this section does not apply to lists that are by law made available to the public, or to lists of professional or occupational licensees.

(11) Student records, including records of a home study student; provided, however, that such records shall be made available upon request under the provisions of the Federal Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g, as may be amended.

(12) Records concerning formulation of policy where such would constitute a clearly unwarranted invasion of personal privacy if disclosed.

(13) Information pertaining to the location of real or personal property for public agency purposes prior to public announcement of the project and information pertaining to appraisals or purchase price of real or personal property for public purposes prior to the formal award of contracts thereof.

(14) Records that are relevant to litigation to which the public agency is a party of record, provided all such matters shall be available to the public after ruled discoverable by the court before which the litigation is pending, but in any event upon final termination of the litigation.

(15) Records relating specifically to negotiation of contracts, including collective bargaining agreements with public employees.

(16) Any voluntary information provided by an individual, corporation, organization,

partnership, association, trustee, estate, or any other entity in the State of Vermont, which has been gathered prior to the enactment of this subchapter, shall not be considered a public document.

(17) Records of interdepartmental and intradepartmental communications in any county, city, town, village, town school district, incorporated school district, union school district, consolidated water district, fire district, or any other political subdivision of the State to the extent that they cover other than primarily factual materials and are preliminary to any determination of policy or action or precede the presentation of the budget at a meeting held in accordance with section 312 of this title.

(18) Records of the Office of Internal Investigation of the Department of Public Safety, except as provided in 20 V.S.A. § 1923.

(19) Records relating to the identity of library patrons or the identity of library patrons in regard to library patron registration records and patron transaction records in accordance with 22 V.S.A. chapter 4.

(20) Information that would reveal the location of archaeological sites and underwater historic properties, except as provided in 22 V.S.A. § 761.

(21) [Repealed.]

(22) [Repealed.]

(23) Any data, records, or information produced or acquired by or on behalf of faculty, staff, employees, or students of the University of Vermont or the Vermont State Colleges in the conduct of study, research, or creative efforts on medical, scientific, technical, scholarly, or artistic matters, whether such activities are sponsored alone by the institution or in conjunction with a governmental body or private entity, until such data, records, or information are published, disclosed in an issued patent, or publicly released by the institution or its authorized agents. This subdivision applies to, but is not limited to, research notes and laboratory notebooks, lecture notes, manuscripts, creative works, correspondence, research proposals and agreements, methodologies, protocols, and the identities of or any personally identifiable information about participants in research. This subdivision shall not exempt records, other than research protocols, produced or acquired by an institutional animal care and use committee regarding the committee's compliance with State law or federal law regarding or regulating animal care.

(24) Records of, or internal materials prepared for, the deliberations of any public agency acting in a judicial or quasi-judicial capacity.

(25) Passwords, access codes, user identifications, security procedures, and similar information, the disclosure of which would threaten the safety of persons or the security of public property.

(26) Information and records provided to the Department of Financial Regulation by a person for the purposes of having the Department assist that person in resolving a dispute with any person regulated by the Department, and any information or records provided by a person in connection with the dispute.

(27) Information and records provided to the Department of Public Service or the Public Utility Commission by an individual for the purposes of having the Department or Commission assist that individual in resolving a dispute with a utility regulated by the Department or Commission, or by the utility or any other person in connection with the individual's dispute.

(28) Records of, and internal materials prepared for, independent external reviews of health care service decisions pursuant to 8 V.S.A. § 4063 and of mental health care service decisions pursuant to 8 V.S.A. § 4064.

(29) The records in the custody of the Secretary of State of a participant in the Address Confidentiality Program described in 15 V.S.A. chapter 21, subchapter 3, except as provided in that subchapter.

(30) All State-controlled database structures and application code, including the vermontvacation.com website and Travel Planner application, which are known only to certain State departments engaging in marketing activities and that give the State an opportunity to obtain a marketing advantage over any other state, regional, or local governmental or nonprofit quasi-governmental entity, or private sector entity, unless any such State department engaging in marketing activities determines that the license or other voluntary disclosure of such materials is in the State's best interests.

(31) Records of a registered voter's month and day of birth, driver's license or nondriver identification number, telephone number, email address, and the last four digits of his or her Social Security number contained in a voter registration application or the statewide voter checklist established under 17 V.S.A. § 2154 or the failure to register to vote under 17 V.S.A. § 2145a.

(32) With respect to publicly owned, managed, or leased structures, and only to the extent that release of information contained in the record would present a substantial likelihood of jeopardizing the safety of persons or the security of public property, final building plans, and as-built plans, including drafts of security systems within a facility, that depict the internal layout and structural elements of buildings, facilities, infrastructures, systems, or other structures owned, operated, or leased by an agency before, on, or after the effective date of this provision; emergency evacuation, escape, or other emergency response plans that have not been published for public use; and vulnerability assessments, operation, and security manuals, plans, and security codes. For purposes of this subdivision, "system" shall include electrical, heating, ventilation, air conditioning, telecommunication, elevator, and security systems. Information made exempt by this subdivision may be disclosed to another governmental entity if disclosure

is necessary for the receiving entity to perform its duties and responsibilities; to a licensed architect, engineer, or contractor who is bidding on or performing work on or related to buildings, facilities, infrastructures, systems, or other structures owned, operated, or leased by the State. The entities or persons receiving such information shall maintain the exempt status of the information. Such information may also be disclosed by order of a court of competent jurisdiction, which may impose protective conditions on the release of such information as it deems appropriate. Nothing in this subdivision shall preclude or limit the right of the General Assembly or its committees to examine such information in carrying out its responsibilities or to subpoena such information. In exercising the exemption set forth in this subdivision and denying access to information requested, the custodian of the information shall articulate the grounds for the denial.

(33) The account numbers for bank, debit, charge, and credit cards held by an agency or its employees on behalf of the agency.

(34) Affidavits of income and assets as provided in 15 V.S.A. § 662 and Rule 4 of the Vermont Rules for Family Proceedings.

(35) [Repealed.]

(36) Anti-fraud plans and summaries submitted for the purposes of complying with 8 V.S.A. § 4750.

(37) Records provided to the Department of Health pursuant to the Patient Safety Surveillance and Improvement System established by 18 V.S.A. chapter 43a.

(38) Records that include prescription information containing data that could be used to identify a prescriber, except that the records shall be made available upon request for medical research, consistent with and for purposes expressed in 18 V.S.A. § 4622 or 9410, 18 V.S.A. chapter 84 or 84A, and for other law enforcement activities.

(39) Records held by the Agency of Human Services or the Department of Financial Regulation, which include prescription information containing patient-identifiable data, that could be used to identify a patient.

(40) Records of genealogy provided in an application or in support of an application for tribal recognition pursuant to chapter 23 of this title.

(41) Documents reviewed by the Victims Compensation Board for purposes of approving an application for compensation pursuant to 13 V.S.A. chapter 167, except as provided by 13 V.S.A. §§ 5358a(b) and 7043(c).

(42) Except as otherwise provided by law, information that could be used to identify a complainant who alleges that a public agency, a public employee or official, or a person providing goods or services to a public agency under contract has engaged in a violation of law, or in waste, fraud, or abuse of authority, or in an act creating a threat to health or safety, unless the complainant consents to disclosure of his or her identity.

(43) Records relating to a regulated utility's cybersecurity program, assessments, and plans, including all reports, summaries, compilations, analyses, notes, or other cybersecurity information.

(44) Records held by the Office of Professional Regulation, Board of Medical Practice, or another public agency that issues one or more licenses, certificates, or registrations to engage in a State-regulated profession or occupation if the records contain the telephone number, email address, physical address, or mailing address, or a combination of these, of an individual who has applied for or has been granted a license, certificate, or registration to practice a profession or occupation in this State, except that the public agency shall disclose any address that the individual has designated as a public address in the record.

(d)(1) On or before December 1, 2015, the Office of Legislative Counsel shall compile lists of all Public Records Act exemptions found in the Vermont Statutes Annotated, one of which shall be arranged by subject area, and the other in order by title and section number.

(2) On or before December 1, 2019, the Office of Legislative Counsel shall compile a list arranged in order by title and section number of all Public Records Act exemptions found in the Vermont Statutes Annotated that are repealed or are narrowed in scope on or after January 1, 2019. The list shall indicate:

(A) the effective date of the repeal or narrowing in scope of the exemption; and

(B) whether or not records produced or acquired during the period of applicability of the repealed or narrowed exemption are to remain exempt following the repeal or narrowing in scope.

(3) The Office of Legislative Counsel shall update the lists required under subdivisions (1) and (2) of this subsection no less often than every two years. In compiling and updating these lists, the Office of Legislative Counsel shall consult with the Office of Attorney General. The lists and any updates thereto shall be posted in a prominent location on the websites of the General Assembly, the Secretary of State's Office, the Attorney General's Office, and the State Library and shall be sent to the Vermont League of Cities and Towns.

(e)(1) For any exemption to the Public Records Act enacted or substantively amended in legislation introduced in the General Assembly in 2019 or later, in the fifth year after the effective date of the enactment, reenactment, or substantive amendment of the exemption, the exemption shall be repealed on July 1 of that fifth year except if the General Assembly reenacts the exemption prior to July 1 of the fifth year or if the law otherwise requires.

(2) Legislation that enacts, reenacts, or substantively amends an exemption to the Public Records Act shall explicitly provide for its repeal on July 1 of the fifth year after the

effective date of the exemption unless the legislation specifically provides otherwise.

(f) Unless otherwise provided by law, a record produced or acquired during the period of applicability of an exemption that is subsequently repealed or narrowed in scope shall, if exempt during that period, remain exempt following the repeal or narrowing in scope of the exemption. (Added 1975, No. 231 (Adj. Sess.), § 1; amended 1977, No. 202 (Adj. Sess.); 1979, No. 156 (Adj. Sess.), § 6; 1981, No. 227 (Adj. Sess.), § 4; 1989, No. 28, § 2; 1989, No. 136 (Adj. Sess.), § 1; 1995, No. 46, §§ 23, 58; 1995, No. 159 (Adj. Sess.), § 2; 1995, No. 167 (Adj. Sess.), § 29; 1995, No. 180 (Adj. Sess.), § 38; 1995, No. 182 (Adj. Sess.), § 21, eff. May 22, 1996; 1995, No. 190 (Adj. Sess.), § 1(a); 1997, No. 159 (Adj. Sess.), § 12, eff. April 29, 1998; 1999, No. 134 (Adj. Sess.), § 3, eff. Jan. 1, 2001; 2001, No. 28, § 9, eff. May 21, 2001; 2001, No. 76 (Adj. Sess.), § 3, eff. Feb. 19, 2002; 2001, No. 78 (Adj. Sess.), § 1, eff. Apr. 3, 2002; 2003, No. 59, § 1, eff. Jan. 1, 2006; 2003, No. 63, § 29, eff. June 11, 2003; 2003, No. 107 (Adj. Sess.), § 14; 2003, No. 146 (Adj. Sess.), § 6, eff. Jan. 1, 2005; 2003, No. 158 (Adj. Sess.), § 2; 2003, No. 159 (Adj. Sess.), § 12; 2005, No. 132 (Adj. Sess.), § 1; 2005, No. 179 (Adj. Sess.), § 3; 2005, No. 215 (Adj. Sess.), § 326; 2007, No. 80, § 18; 2007, No. 110 (Adj. Sess.), § 3; 2007, No. 129 (Adj. Sess.), § 2; 2009, No. 59, § 5; 2009, No. 107 (Adj. Sess.), § 5, eff. May 14, 2010; 2011, No. 59, § 3; 2011, No. 78 (Adj. Sess.), § 2, eff. April 2, 2012; 2011, No. 145 (Adj. Sess.), § 8, eff. May 15, 2012; 2013, No. 70, § 1; 2013, No. 129 (Adj. Sess.), § 1; 2013, No. 194 (Adj. Sess.), § 1, eff. June 17, 2014; 2015, No. 23, § 2; 2015, No. 29, §§ 2, 3, 6, 23; 2015, No. 30, § 3, eff. May 26, 2015; 2015, No. 80 (Adj. Sess.), § 6, eff. July 1, 2017; 2017, No. 50, § 5; 2017, No. 128 (Adj. Sess.), § 2, eff. May 16, 2018; 2017, No. 166 (Adj. Sess.), § 3, eff. Jan. 1, 2019; 2019, No. 31, § 16; 2021, No. 54, § 2; 2023, No. 3, § 59, eff. March 20, 2023; 2025, No. 11, § 3, eff. September 1, 2025; 2025, No. 20, § 2, eff. May 13, 2025.)

The Vermont Statutes Online

The Statutes below include the actions of the 2025 session of the General Assembly.

NOTE: The Vermont Statutes Online is an unofficial copy of the Vermont Statutes Annotated that is provided as a convenience.

Title 33 : Human Services

Chapter 063 : Home Care Programs

Subchapter 001A : GENERAL PROVISIONS

(Cite as: 33 V.S.A. § 6303)

§ 6303. Home health services; local plans; board composition

(a) Consistent with the requirements of this section, the Commissioner of Disabilities, Aging, and Independent Living shall adopt by rule minimum program standards for the purpose of providing quality oversight of the home health agencies authorized to provide home health services under this subchapter. The minimum program standards shall include performance standards, quality measures, grievance and complaint procedures, patient safety standards, consumer input mechanisms, accessibility standards, medical necessity standards, and practices to ensure confidentiality of patient records. The rules shall also include minimum program standards to ensure home health agencies do not discriminate in the provision of services based on income, funding source, geographic status, or severity of health needs and to ensure the attainment or continuance of universal access to medically necessary home health services.

(b) Designated home health agencies shall engage in planning and needs assessment processes as directed by State and federal law, which may include participating in the development of the Health Resource Allocation Plan published pursuant to 18 V.S.A. § 9405 and the community health needs assessment conducted in accordance with 26 U.S.C. § 501(r)(3).

(c) On or before January 1, 2008, the board of each nonprofit designated home health agency shall be representative of the demographic makeup of the area or areas served by the agency or by the health care facility governed by the board. A majority of the members of the board shall be composed of individuals who have received or currently are receiving services from the agency or from the health care facility governed by the board and family members of individuals who have received or currently are receiving such services. The board president shall survey board members annually and certify to the Commissioner that the composition of the board meets the requirements of this

subsection. The composition of the board shall also be confirmed by the agency's annual independent audit. The board shall have overall responsibility and control of the planning and operation of the home health agency, including development of the local community services plan.

(d) On or before January 1, 2008, each for-profit designated home health agency shall have an advisory board, which shall be representative of the demographic makeup of the area or areas served by the agency. A majority of the members of the advisory board shall be composed of individuals who have received or currently are receiving services from the agency and family members of individuals who have received or currently are receiving such services. The advisory board president shall survey board members annually and certify to the Commissioner that the composition of the board meets the requirements of this subsection. The composition of the board shall also be confirmed by the agency's annual independent audit. The advisory board shall meet at least twice per year and shall advise the agency's board of directors with respect to planning and operation of the home health agency, patient needs, and development of the local community services plan.

(e) [Repealed.] (Added 2005, No. 57, § 8, eff. June 13, 2005; amended 2009, No. 33, § 83; 2015, No. 11, § 38; 2019, No. 156 (Adj. Sess.), § 7a, eff. Oct. 5, 2020.)

VERMONT

Proposed Rules Postings
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Search Rules

Deadline For Public Comment

Deadline: Aug 15, 2025

The deadline for public comment has expired. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	25P021
Title:	Rules for the Designation and Operation of Home Health Agencies.
Type:	Standard
Status:	Proposed
Agency:	Department of Disabilities, Aging and Independent Living; Agency of Human Services
Legal Authority:	33 V.S.A. § 6303, and 3 V.S.A. § 801(b)(11)
Summary:	It is not uncommon for designated home health agencies, despite their best efforts to recruit and retain staff, to lack the necessary staffing to provide designated services, as currently defined, to all

	individuals who are referred. The severe workforce shortage of personal care attendants prevents home health agencies from complying with the requirement to serve all individuals on Choices for Care who are referred for services. As a result, most agencies are operating under a variance to this requirement. The proposed rule would remove Choices for Care services, including personal care, respite, companionship, and homemaker services, which are not "home health services," from the Rule's definition of "designated services," to ensure that agencies are not held responsible for providing services that they frequently lack staffing to provide, while allowing them to continue to provide these services when they do have sufficient staff. The proposed rule makes other technical changes for clarity.
Persons Affected:	Department of Disabilities, Aging, and Independent Living; Home Health Agencies; Area Agencies on Aging; Vermont Legal Aid, including the State Long-Term Care Ombudsman Program; Home Health patients; and Choices for Care participants.
Economic Impact:	This rule change is expected to have minimal economic impact. As a result of this change, home health agencies will no longer be out of compliance with these Rules if they are unable to provide personal care, respite, companionship, and homemaker services to those enrolled in Choices for Care. Home health agencies will continue to provide these services as they are able, as they do now. The rule change will also enable home health agencies to focus their resources on the delivery of designated services and will create an opportunity to expand the number of providers authorized to deliver these non-medical Choices for Care services to beneficiaries throughout the state.
Posting date:	Jun 18,2025

Hearing Information

Information for Hearing # 1

Hearing date:	08-05-2025 12:00 PM ADD TO YOUR CALENDAR
Location:	Virtually via Zoom
Address:	https://www.zoomgov.com/j/1605733457?pwd31awleU2boG8JpBGcRfqMPbRoYyaNa.1
City:	n/a
State:	VT

Zip:	n/a
Hearing Notes:	Virtually via Zoom at: https://www.zoomgov.com/j/1605733457?pwd31awleU2boG8JpBGcRfqMPbRoYyaNa.1

Information for Hearing # 2

Hearing date:	08-07-2025 12:00 PM ADD TO YOUR CALENDAR
Location:	Virtually via Zoom
Address:	https://www.zoomgov.com/j/1603660486?pwdIul7qGTD4ZzwsfNjERY7UZPZ4wcG3O.1
City:	n/a
State:	VT
Zip:	n/a
Hearing Notes:	Virtually via Zoom at: https://www.zoomgov.com/j/1603660486?pwdIul7qGTD4ZzwsfNjERY7UZPZ4wcG3O.1

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

Level:	Primary
Name:	Pamela Cota
Agency:	Department of Disabilities, Aging and Independent Living; Agency of Human Services
Address:	HC 2 South, 280 State Drive
City:	Waterbury
State:	VT
Zip:	05671-2060
Telephone:	802-241-0347
Fax:	
Email:	pamela.cota@vermont.gov SEND A COMMENT
Website Address:	https://dlp.vermont.gov/survey-cert/facility-regs VIEW WEBSITE

Information for Secondary Contact

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON.

Level:	Secondary

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Keyword Information

Keywords:

home health agencies
designation
Choices for Care
designated services

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	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** February 19, 2026

RE: The "Proposed State Rules " ad copy to run on **June 26, 2025**

PAGES INCLUDING THIS COVER MEMO: **2**

NOTE **8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

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By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

Rules for the Designation and Operation of Home Health Agencies.

Vermont Proposed Rule: 25P021

AGENCY: Agency of Human Services, Department of Disabilities, Aging and Independent Living (DAIL)

CONCISE SUMMARY: It is not uncommon for designated home health agencies, despite their best efforts to recruit and retain staff, to lack the necessary staffing to provide designated services, as currently defined, to all individuals who are referred. The severe workforce shortage of personal care attendants prevents home health agencies from complying with the requirement to serve all individuals on Choices for Care who are referred for services. As a result, most agencies are operating under a variance to this requirement. The proposed rule would remove Choices for Care services, including personal care, respite, companionship, and homemaker services, which are not "home health services," from the Rule's definition of "designated services," to ensure that agencies are not held responsible for providing services that they frequently lack staffing to provide, while allowing them to continue to provide these services when they do have sufficient staff. The proposed rule makes other technical changes for clarity.

FOR FURTHER INFORMATION, CONTACT: Pamela Cota, Department of Disabilities, Aging and Independent Living (DAIL) HC 2 South, 280 State Drive Waterbury, VT 05671-2060 Tel: 802-241-0347 E-Mail: pamela.cota@vermont.gov URL: https://dlp.vermont.gov/survey-cert/facility-regs.

FOR COPIES: Stuart Schurr, Department of Disabilities, Aging and Independent Living (DAIL) HC 2 South, 280 State Drive Waterbury, VT 05671-2060 Tel: 802-238-3754 E-Mail: stuart.schurr@vermont.gov.
