STATE OF VERMONT

HUMAN SERVICES BOARD

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| In re | ) | Fair Hearing No. B-03/21-188 |
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| Appeal of | ) | |
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## INTRODUCTION

Petitioner appeals the denial of Medicaid "high needs" or "highest needs" Choices for Care (CFC) eligibility by the Department of Disabilities, Aging and Independent Living (DAIL or Department). The following is based on hearings held by telephone (petitioner and her counsel) and video June 3rd and September 17, 2021, and documents submitted by the Department.

## FINDINGS OF FACT

1. The sole issue in petitioner's appeal is her application for assistance with bathing through the CFC "high/highest needs" categories; bathing is one of the "activities of daily living" (ADLs) addressed in the "high/highest needs" categories.

2. Petitioner lives in an apartment in a senior residential facility and is currently receiving CFC services in the "moderate needs" category. She receives housekeeping services through Age Well and receives Adult Day services,

although that program has been limited due to the COVID pandemic. The Adult Day service program does provide assistance with bathing; but again, the program was temporarily closed during the time of the application (and slated to reopen later in 2021). In the meantime, for a period of time petitioner requested and received assistance with bathing through the SASH program (Support and Services at Home, a program that coordinates resources for senior Vermonters who choose to live at home) and with funding assistance from Age Well, but that funding has ended. Petitioner's Age Well caseworker then assisted petitioner in applying for CFC in the "high/highest" needs categories on January 11, 2021. The case worker, who is not a nurse, testified that she filed the application as petitioner's services for assistance with bathing were ending and she had concerns, based on her conversation with the SASH worker (who had been assisting petitioner with bathing) and the Home Health worker that petitioner had trouble bending over, and therefore, in her opinion, needed assistance with bathing. However, it must be noted that a determination of clinical eligibility for the "high/highest needs" group needs to be made by a registered nurse.

3. Petitioner was (first) assessed by the Department for clinical eligibility, by video, with petitioner at her home, on February 3, 2021. The assessor reviewed petitioner's medical records which indicate that she has been diagnosed with COPD (chronic obstructive pulmonary disease), hyperthyroidism, vision problems, left hip pain, left shoulder pain, lumbago, and other medical problems. The assessor was a long-term clinical care coordinator who is a Registered Nurse with 27 years of nursing experience.

4. CFC eligibility determinations involve an assessment of an applicant's functional performance in nine areas of activities of daily living (ADLs) within their home: however, the ADL of bathing is the only function at issue in this case. Applicants are assessed as to their functional ability based on a scale starting with "independent" to "[needs] supervision" to "[needs] limited assistance" to "[needs] extensive assistance" and finally to "total dependence."

5. The assessment form utilized by the Department contains the following guidance for each level of need, with respect to bathing:

- independent: no help at all.

- supervision: oversight/cueing only.
- limited assistance: physical help limited to transfer only.
- extensive assistance: physical help in part of bathing activity.
- total dependence: full assistance every time

6. Petitioner was independent in all but one category of ADLs and needed "limited assistance" with bathing.

7. As a result of this assessment, the Department determined that petitioner was not eligible for "high" or "highest" needs CFC. There are different eligibility triggers for the "high" and "highest" needs groups, but at minimum, for eligibility for the "high needs" group, petitioner would have had to demonstrate the need for either extensive or total assistance with bathing on a daily basis. DAIL mailed a letter to petitioner dated March 1, 2021, informing her that she had been determined ineligible for CFC because she did not meet the clinical requirements for nursing home level of care.

8. The testimony of the nurse assessor at hearing was highly credible based on her lengthy experience in conducting these assessments. The assessor observed petitioner's demonstrations of her functionality with the ADLs by video.

She documented petitioner's responses regarding her ability to perform ADLs on the assessment form.

9. In responding to the assessment questions regarding bathing, petitioner reported that she needed assistance getting into and out of the shower. However, she also indicated that she now had a walk-in shower and a seat in the shower. She also reported needing assistance washing her back and her hair, due to a reported limitation in her shoulder range of motion resulting in trouble keeping her arms raised. Finally, petitioner reported that she needed assistance washing her lower legs and feet. Petitioner reported that she has had a hernia in the past and that it is difficult for her to bend over and that she becomes dizzy when bending over.

10. The assessor testified that the ADL of bathing covers getting into the shower or bath and washing the body (other than the back) but as noted on the form, it excludes hair washing or washing one's back[1]. Needing assistance with transfer to and from the shower is defined as being within

[1] Petitioner argues that the exclusion of hair and back washing from the bathing assessment is not supported by any definition of bathing in the Regulations. The assessor testified that the assessment tool is a nationally used tool and the form has been in place since the program's inception in 2005. In any event, the Department is entitled to deference in its interpretation of the terms utilized in its Regulations and forms. See Jacobus v. Depart. Of PATH, 2004 VT 70, ¶23.

the category of needing "limited assistance" with bathing. With respect to the final factor of petitioner washing her lower legs and feet, the assessor noted that petitioner could use a long-handled brush to assist her and prevent bending over. Similarly, petitioner currently uses a "claw" or stick device to assist her in dressing. Based on the evidence presented regarding the June assessment, petitioner was not eligible for LTC CFC Medicaid[2].

11. Petitioner requested a fair hearing regarding this decision.

12. After the first hearing in this case in June 2021, the Department agreed to complete a new assessment. Then, petitioner was hospitalized for a medical condition and was subsequently transferred to a rehabilitation facility for a period of time (two separate stays from July 19th–30th and then August 2nd–6th) before she returned home on August 6th. The same assessor performed a new in-person assessment of August 9, 2021, at petitioner's home. At that time, the assessor noted that petitioner needed "extensive assistance" with bathing. This was based on petitioner's report that she was just starting to work with physical therapy/occupational

[2] There are other qualifying criteria that are not at issue in this case. See HCAR § 7.102.5 (a)(6)(A)(ii)(iii)(iv)(v) and § 7.102.5(B)(ii)(iii)(iv)(v)(vi)(vii).

therapy at the rehabilitation facility with using the long-handled brush before she left the facility. Subsequently, the assessor reviewed the notes from the physical therapy/occupational therapy that petitioner received at the rehabilitation facility. Those notes stated that petitioner needed supervision for tub/shower transfers and that the goal for washing her lower body was to give her training in using the long-handled brush and that as of August 4th, petitioner "demonstrated effective use of a large sponge and reacher with set up only." The assessor determined that once petitioner had that training she would be back to needing "limited assistance" with bathing.

13. Unfortunately, petitioner left the rehabilitation facility on August 6th before receiving more training because her insurance (the parties were not clear which coverage ran out) would not cover any additional days.

14. Here, the facts became somewhat complex. Because the assessor found that only sub-acute rehabilitation care was warranted, the Department was then informed by the Department of Vermont Health Access (DVHA) that petitioner no longer met financial CFC eligibility because short-term rehabilitation services would be provided in the rehabilitation facility and would be paid for by petitioner's

community Medicaid. That decision by DVHA is not under review in this case but is mentioned to explain the chain of events in the case. In any event, petitioner did not choose to go back to the rehabilitation facility and did not receive any additional PT/OT to train her in using the long-handled brush.

15. In summary, petitioner argues that, based on both assessments (with emphasis on the August assessment) CFC clinical eligibility should be found so that she can receive assistance with bathing in her home. The Department counters that petitioner is not eligible for CFC in the "high/highest needs" categories based on either assessment and that the August 9th assessment only supports the need for sub-acute rehabilitation care (paid for by community Medicaid) and which is distinct from services provided by "high/highest needs" LTC coverage. The Department correctly found that the LTC Program Regulations require that the clinical assessor make a finding about whether rehabilitation services or long-term care services are required and also make a finding as to whether other services are available to the petitioner to meet identified needs before clinical eligibility can be found. Therefore, based on the evidence presented about the August 9th assessment, the assessor's finding that petitioner

was eligible for "sub-acute" rehabilitation care and not LTC "high/highest needs" eligibility is supported by the record and is correct.

ORDER

DAIL's decision is affirmed.

REASONS

Review of the Department's determination is de novo. The Department has the burden of proof at hearing if terminating or reducing existing benefits; otherwise, the petitioner bears the burden. *See* Fair Hearing Rule 1000.3.0.4.

The Department administers the CFC program, which falls under a Medicaid waiver intended to maximize independence and provide services which enable individuals who need a nursing home level of care to remain in the community.

> The primary goal of the Choices for Care waiver is to provide Vermonters with equal access to licensed nursing facility, licensed residential care/assisted living, or home and community-based services, consistent with their choice.

Health Care Administrative Rules (HCAR) § 7.102.01(c).

The CFC implementing regulations set out the eligibility criteria for the program. *See* HCAR § 7.102.5 While there are different triggers for the "high needs" and "highest

needs" categories, the only factor at issue here is petitioner's need for assistance with the ADL of bathing.

Individuals may be clinically eligible under the "highest needs group" if they require extensive or total assistance with at least one of the following Activities of Daily Living (ADLs): toilet use; eating; bed mobility; or transfer, and require *at least* limited assistance with any other ADL." HCAR § 7.102(6)(A)(i). *Id.* (emphasis in original). Individuals may be eligible under the "high needs group" if they "require extensive-to-total assistance with at least one of the following ADLs: Bathing, Dressing, Eating, Toilet Use, [and] Physical Assistance to Walk." HCAR § 7.102(6)(A)(i).

With respect to the February 2021 assessment, the evidence in the record fails to show that petitioner needed extensive assistance in any ADL listed in the regulations. Therefore, she is not eligible under the "highest needs" category.

With respect to eligibility under the "high needs" category, hair and back washing are not included within the definition of the bathing ADL. See Fair Hearing No. B-02/12-88. And needing assistance getting in and out of the tub or shower demonstrates only a need for "limited assistance."

Id. There was no evidence presented in the February assessment to show that petitioner needs extensive assistance with bathing, as required by the Regulations, therefore, she is also ineligible under the "high needs" category.

However, this case is then complicated by the information presented in the later August 9th assessment. Again, the limited question presented is whether petitioner's need for assistance with bathing qualifies her for "high/highest needs" LTC.

Petitioner argues that in the August 9th (current) assessment the Department found petitioner needed "extensive care" with bathing, making her eligible for the "high needs" category and that petitioner opts to get that service in her home.

The Department's argues that in conducting the assessment it is required to determine whether the individual needs rehabilitation services or long-term care services.

> Determination of clinical eligibility is a skilled nursing function conducted by a registered nurse (RN). Accurate clinical assessment requires the consideration of a number of variables that affect and individual's clinical eligibility. . . In other instances, the RN must determine whether an individual is currently receiving adequate services to meet identified needs from other non-waiver sources. *If an individual's needs could be met through private and/or other community resources (whether or not they are), the individual will not be eligible for the Choices for Care Program*.

VT DAIL Choices for Care, High/Highest Program Operations Manual (Manual) Section II [Eligibility], III [Choices for Care Clinical Eligibility](emphasis added). See also Manual Section II, III, A (7) [Highest Need Group] ("For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.") and Manual § II, III, B, 7 [High Needs Group].

Petitioner's current need, as found by the assessor and noted in the August 9th assessment, after review of the PT/OT rehabilitation staff notes, is for additional short-term rehabilitation to bring petitioner's skills up to the point that she can use the long-handled brush independently.

And, the Department argues that CFC LTC is not intended to provide short-term rehabilitation services in the home, but rather to provide long-term services. See HCAR § 7.102.4 [Covered Services](chart not listing short-term rehabilitation services). This argument is further supported by Medicaid Covered Services Rules S 7317 that provides that therapy services, to include rehabilitate functions that affect the activities of daily living, are a covered service

under (community) Medicaid. Medicaid Covered Services Rules § 7317 [Rehabilitative Therapy Services].

In further support of its argument, the Department relies on provisions of the Manual that state that if other services are available to an individual to meet needs, then CFC eligibility is not triggered. First, it argues that CFC is not intended to "replace or supplant services otherwise provided under (other) Medicaid waivers." Manual § II, I [Standard for Eligibility]. The Department argues that when short-term rehabilitation services are what is needed, as in this case, the individual is not required to be eligible (or file an application for) LTC Medicaid; rather community Medicaid would be the entity to cover rehabilitation stays of 30 days or less. Manual § II, II B. [Short-term Rehab in a Nursing Facility] and § V.5 K [Short-term Rehab in a Vermont Nursing Facility] 5 and 7.

Then, when an individual who has been found to need extensive rehabilitation assistance with an ADL is to be discharged from a rehabilitation facility, the Program procedures reflect that the rehabilitation caseworker contacts the LTC coordinator to do a reassessment to determine if any long-term care services, covered under CFC are needed. Id. Manual § V.5 14.

There is no question that CFC Program Regulations provide that the Department is required to operate the "high/highest needs" CFC program in a cost-effective manner that uses resources efficiently and to inform individuals of other feasible service alternatives. HCAR § 7.102.3 [General Policies].

> Choices for care shall not provide or pay for services to meet needs that can be adequately met by services Available through other sources. This includes but is not limited to Medicare, Medicaid and private insurance coverage.

HCAR § 7.102.10 (a)[Limitations].

To say that the Department's Regulations and Policies on this issue are both complex and confusing is an understatement. But, given the CFC Program Regulations require the clinical assessor to (1) make a determination whether short-term rehabilitation services or long-term care services are needed, and in connection with that decision also (2) determine whether other services are available to meet the individual's needs as a precursor to CFC eligibility, the Department's actions were consistent with the Rules.

As such, DAIL's denial of petitioner's CFC "high/ highest needs" eligibility is consistent with the applicable

rules and must be affirmed. *See* 33 V.S.A. § 3091(d); Fair Hearing Rule No. 1000.4D.

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