

**The Vermont
Money Follows the Person Rebalancing Demonstration
Appendices**



Submitted by:

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

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APPENDIX A
CHOICES FOR CARE EMPLOYER HANDBOOK FOR SELF DIRECTION

Choices for Care
Vermont Long-Term Care Medicaid

Employer Handbook
Consumer and Surrogate Directed Services

Revised July 2009

This information is important. If you do not understand it, take it to your local office for help.

Ces informations sont importantes. Si vous ne les comprenez pas, apportez-les à votre bureau local pour recevoir de l'aide. **French**

Это важная информация. Если она Вам непонятна, возьмите это письмо и обратитесь за помощью в местное отделение. **Russian**

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. **Serbo-Croatian**

Esta información es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda. **Spanish**

Maelezo ya barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi. **Swahili**

Thông tin này rất quan trọng. Nếu quý và không hiểu nội dung trong này, hãy đem thư này đến văn phòng tại địa phương của quý và nếu cần giúp đỡ.
Vietnamese

Vermont Agency of Human Services
 Department of Disabilities, Aging and Independent Living
 Division of Disability and Aging Services
 103 South Main Street – Weeks 2
 Waterbury, Vermont 05671-1601
 802-241-1228 (voice/ttd)
www.dail.state.vt.us

Payroll Agent:
ARIS Solutions
P.O. BOX 4409
White River Junction, VT 05001
1-800-798-1658

This document is available in alternative format upon request.

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CHAPTER I: Introduction

The Vermont Department of Disabilities, Aging and Independent Living (DAIL) manages the Choices for Care (CFC) program. The goal of this program is to offer eligible elders and adults with physical disabilities a choice of long-term care services in the setting they choose.

In the Home-Based setting, the CFC program offers three services that may be directed by the individual (consumer-directed) or a surrogate employer. These services include:

- Personal Care
- Respite Care
- Companion Services

Being an **EMPLOYER** is a big responsibility and should not be taken lightly. If an individual who is participating in the CFC program is able and willing to be an **EMPLOYER** for their own Personal Care, Respite or Companion services, they may apply for the consumer-directed option. However, if the individual is not able or willing to be the employer, a trusted friend or family member may apply to be the surrogate-directed **EMPLOYER**.

Whether consumer or surrogate directed, the CFC case manager must certify that the individual or surrogate is eligible to be the **EMPLOYER**. Once certified, the **EMPLOYER** agrees to perform all activities required to hire, train, and supervise personal care attendants, respite and/or companion employees. This manual will help **EMPLOYERS** understand their responsibilities as well as the CFC program requirements.

CHAPTER II: Eligibility

1. Program Eligibility

To be eligible for the Choices for Care (CFC) program, an individual must:

- a) be a Vermont resident;
- b) be at least 65 years of age, or 18 or older and have a physical disability;
- c) be financially eligible for Long-Term Care Medicaid;
- d) meet the clinical criteria;
- g) make an informed choice to accept CFC services in a Service Plan.

Individuals who wish to direct their own services must also meet the following **EMPLOYER** eligibility guidelines.

2. Employer Eligibility

The CFC case manager must certify that any individual or surrogate who wishes to be an **EMPLOYER** of services. As a part of this process the case manager will complete an “Employer Certification Form”.

All consumer or surrogate-directed **EMPLOYERS** must have the cognitive ability to communicate effectively and perform the activities required of an employer. Cognition and communication are defined as follows:

- a. **Cognition:** the ability to understand and perform the tasks required to employ a caregiver (including recruitment, hiring, scheduling, training, supervision, and termination). An individual who has cognitive impairments or dementia that prevent understanding and performance of these tasks, is not competent, or has a guardian, is not eligible to manage waiver services.
- b. **Communication:** the ability to communicate effectively with the case manager and with the caregiver(s) in performing the tasks required to employ a caregiver. An individual, who cannot communicate effectively, whether through verbal communication or alternate methods, is not eligible to manage waiver services.

In addition, the **EMPLOYER** must live within close proximity to the individual in order to monitor services and supervise employees adequately. Employers must demonstrate over time that they have the ability to understand program rules and to reliably perform employer responsibilities. If the individual or surrogate is not able or willing to be the **EMPLOYER**, the case manager will discuss other options.

CHAPTER III: Program Limitations

The Choices for Care (CFC) program has the following limitations under the consumer or surrogate directed option:

1. Consumer and surrogate employers are **not** paid by the CFC to direct and manage services.
2. An individual's legal guardian (appointed by a probate court) may **not** be paid to provide services under CFC.
3. An employee who is paid by CFC to provide services for the individual may **not** also serve as the surrogate employer.
4. Employees must be 18 years of age or older.
5. CFC only provides services and care for the individual who has been found eligible. Therefore, services are **restricted to the benefit of the individual**.
6. Persons with any of the following may not be paid to provide services under the CFC program (*DAIL Background Check Policy, July 1, 2009*):
 - a. a substantiated history of abuse, neglect, or exploitation of an adult or child;
 - b. exclusion from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General; or
 - c. a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust.
7. An individual's spouse or civil union partner may **not** be paid to provide companion services or respite services under the CFC program.
8. An individual's spouse or civil union partner may **not** be paid to provide personal care assistance with Instrumental Activities of Daily Living such as meal prep, medication management, phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment.
9. Employees are not paid to provide services while the individual is admitted to a hospital or nursing facility.
10. Individuals may remain eligible for CFC up to **30 days** while absent from the state of Vermont.

11. Individuals may use their CFC services up to **7 days** while absent from the state of Vermont.
12. Surrogate employers shall not be certified to manage CFC services for more than two (2) individuals at one time.
13. CFC shall not be used to provide services that are otherwise being purchased privately or through another funding source.

CHAPTER IV: Service Descriptions

Choices for Care (CFC) covers the following consumer and surrogate-directed services in the Home-Based setting.

1. Personal Care Services

Personal Care Services may include help with the following:

- Dressing
- Bathing
- Grooming (help with brushing teeth, shaving, hair and skin care)
- Bed mobility (moving about while in bed)
- Toilet use
- Personal hygiene and clean up related to incontinence
- Assistance with adaptive devices
- Transferring (help getting to and from chair and bed)
- Mobility (help with walking or using a wheelchair)
- Eating

When needed, services may also include the following **for the individual only**:

- Help using the telephone
- Preparing meals
- Heavy housekeeping: for example, mopping floors and taking out garbage
- Light housekeeping: for example, changing the bed, dusting, vacuuming and doing laundry
- Shopping
- Travel assistance necessary for the person's health and welfare
- Care of adaptive equipment

The case manager together with the participant completes a **“Personal Care Worksheet”** and **“Service Plan”**. The case manager will provide the **EMPLOYER** with a copy of the Personal Care Worksheet. The Personal Care Worksheet describes the specific tasks and services that shall be provided for the individual. The Service Plan identifies the overall type and amount of services the individual has been approved to receive. The Personal Care Worksheet and Service Plan shall be used by the **EMPLOYER** to plan service schedules and approve timesheets.

2. Respite Care Services

Respite Care services are designed to provide a break or relief from care to the individual's primary, unpaid caregiver (e.g. spouse). Respite Care services are based on blocks of time, rather than on specific tasks. Respite Care may include supervision as well as the specific tasks described under Personal Care services. Only individuals who have an unpaid primary caregiver are eligible to receive Respite Care services. A maximum of **720 hours a calendar year** is available. If the individual also receives Companion services, the combined total may not exceed 720 hours a calendar year.

3. Companion Services

Companion services include non-medical care, supervision and socialization. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities on an ongoing basis. A maximum of **720 hours a calendar year** is available. If the individual also receives Respite Care services, the combined total may not exceed 720 hours a calendar year.

CHAPTER V: Employer Responsibilities

1. Employer Responsibilities

The Choices for Care (CFC) consumer and surrogate directed services are a wonderful option for many people. However, this option is not suited for everyone. Being an **EMPLOYER** is an important responsibility and should not be taken lightly. Please consider the following responsibilities before enrolling as an **EMPLOYER**.

The consumer or surrogate **EMPLOYER** must agree to perform the following ongoing tasks:

- ◆ Understand and follow program requirements
- ◆ Recruit and select qualified employee(s) that are 18 years of age or older
- ◆ Interview applicants and carefully check references before you offer anyone employment
- ◆ Notify selected employee(s) of their responsibilities
- ◆ Assure that employment forms are completed and submitted to the payroll agent (See Chapter VIII)
- ◆ Train employee(s) to perform specific tasks as needed
- ◆ Develop a work schedule based on the approved Service Plan
- ◆ Maintain updated copies of approved waiver Service Plan
- ◆ Arrange for substitute or back-up employees as needed
- ◆ Develop and maintain a list of tasks for the employee(s) to perform based on the Personal Care Worksheet
- ◆ Authorize employee(s) timesheets (based on the approved Service Plan and actual time worked)
- ◆ Maintain copies of all employee(s) timesheets
- ◆ Perform supervisory visits in the home of the individual at least once every thirty (30) days in order to assure that tasks are performed by the employee correctly and completely
- ◆ Evaluate employee(s) performance
- ◆ Provide ongoing performance feedback to employee(s)
- ◆ Terminate employee(s) employment when necessary
- ◆ Notify the payroll agent of any necessary changes
- ◆ Participate in the assessment and reassessment of CFC eligibility
- ◆ Communicate with the case manager on a regular basis (See Chapter IX.)
- ◆ If applicable, assure a monthly patient share is paid to the payroll agent (See Chapter VIII.)
- ◆ Track use of Respite and Companion service hours, so as not to exceed 720 hours a calendar year (See Chapter IV)
- ◆ Avoid conflict of interest with employees, the individual and/or other participating agencies

NOTE: Surrogate employers must live in close proximity to the individual and be available to perform the above employer responsibilities on an ongoing basis.

2. How to Find and Keep a Caregiver

EMPLOYERS may refer to the “**Help at Home: A Guide to Finding and Keeping Your Caregiver**” (published by Homeshare Vermont, Burlington, VT), for helpful information and tips on hiring, training and keeping caregivers/workers. **EMPLOYERS** may obtain a guide by contacting the Choices for Care case manager or Homeshare Vermont at (802) 863-5625 or <http://www.homesharevermont.org/>.

CHAPTER VI: How to Apply and Enroll

Once an applicant has been enrolled in Choices for Care (CFC), a case manager will assess their needs and assist the applicant through the process. The following outlines the steps involved with certifying **EMPLOYERS**, enrolling **EMPLOYERS** and **EMPLOYEES**.

1. Certification of Employer Eligibility

All consumer or surrogate directed **EMPLOYERS** must be certified as able and willing to direct Choices for Care services. Surrogate employers must live in close proximity to the individual and be **available** to perform the employer responsibilities on an ongoing basis.

a. Certification

During the initial assessment process, the case manager completes an “Employer Certification Form”. The case manager must verify and document that the prospective consumer or surrogate employer is able (as described under “Eligibility”) and willing to direct and manage services. By signing the Service Plan and Employer Agreement form the **EMPLOYER** agrees to perform the required activities. The case manager will continue to monitor the employer’s ongoing eligibility during monthly contact and annual reassessments.

b. Non-Certification

If the case manager determines that the consumer or surrogate is not able to perform the ongoing tasks required as the **EMPLOYER**, the individual shall be notified of the decision in writing. The notice will include appeal rights.

2. Enrolling Employers

Once certified, all consumer and surrogate directed **EMPLOYERS** must enroll in the payroll system as described below:

- a. **Contact Payroll Agency:** Certified **EMPLOYERS** must contact the following payroll agent to obtain the necessary forms to become enrolled in the payroll system:

ARIS Solutions
P.O. BOX 4409
White River Junction, VT 05001
1-800-798-1658

b. EMPLOYER Forms: The following forms must be completed by the **EMPLOYER** and returned to the payroll agent in order to enroll in the payroll system:

- Form 2678 Employer Appointment of Agent Form (IRS # 2678)
- Consumer/Surrogate Directed Employer Agreement Form
- Worker's Compensation Authorization Form
- Power of Attorney Form
- Consumer Information Form

Important: Timesheets cannot be processed, nor can payments to workers be made, until ARIS has an approved Service Plan and all of these forms have been received and processed by the payroll agent.

3. Enrolling Employees

Once the employer has located a suitable **EMPLOYEE(S)**, the **EMPLOYEE** must complete the following forms and return to the payroll agent. **This applies to both new employees and returning employees who have not been employed by the consumer in the current calendar year:**

- Form W-4 Employee's Withholding Allowance Certificate
- Form I-9 Employment Eligibility Verification Form
- Record Check Release Form Vermont Criminal Information Center
- Consent for Release of Information Adult Protective Services
- Background Check Release Form
- Optional: Form W-5 Earned Income Credit Advance Payment Certificate
- Optional: Direct Deposit Form

Important: Timesheets cannot be processed, nor can payments to workers be made, until ARIS has an approved Service Plan and all of these forms (not including optional forms) have been received and processed by the payroll agent.

EMPLOYERS should notify their employees that there may be a delay of several weeks before the first paycheck is issued. **EMPLOYERS** may wish to discuss this issue with the CFC case manager, as well.

CHAPTER VII: Employee Eligibility and Restrictions

1. Employee Eligibility

All **EMPLOYEES** must be legally eligible for employment under state and federal laws. In addition, for the Long-Term Care Medicaid (CFC) program, eligible **EMPLOYEES** must:

- be aged 18 years old or over, and
- be able and willing to perform required tasks, and
- be legally eligible to work in the state of Vermont
- Must not have a history of a substantiation of child or adult abuse, neglect or exploitation, a conviction of a violent crime, money crime or felony drug offence or any other conviction as indicated on the State of Vermont Background Check policy

On a case-by-case basis, the Department of Disabilities, Aging and Independent Living (DAIL) may approve an employee under the age of 18 to provide services when the employee has the experience and skills specific to working with elders with functional limitations or individuals with disabilities. Requests must be presented in writing to DAIL.

2. Employee Restrictions

There are some important program limitations that apply to all Employees. Please read **Chapter III. Program Limitations** carefully.

CHAPTER VIII: Payroll Policies and Procedures

1. Payroll Agent

Payroll services are provided by the Choices for Care (CFC) program, through a contracted payroll agency. The payroll agent will process timesheets, paychecks and taxes, maintain employment tax records for employees and perform related payroll activities, including background checks for substantiated incidents of abuse, neglect, or exploitation of others and for criminal records.

The payroll agent for the CFC is:

ARIS Solutions
P.O. BOX 4409
White River Junction, VT 05001
1-800-798-1658

The payroll agent will provide employers and employees with:

- All of the necessary employment forms,
- Timesheet forms,
- Pre-stamped addressed envelopes for mailing timesheets to the payroll agent,
- Annual W-2 tax statements to employees
- Instructions and technical assistance in completing forms

2. Submitting Timesheets

All employee timesheets must be submitted in the following manner:

- The timesheet must be completed correctly, including the dates and times of service.
- The employer must sign the timesheet to verify that services were received.
- The timesheet must be completed correctly, and legibly, including the signatures of both the employee and the employer.
- The timesheet must be submitted to the payroll agent according to the payroll schedule (See appendix).
- **NOTE:** ARIS will not accept **FAXED** timesheets.

Important: Neither DAIL nor the payroll agent are responsible for delays in payment caused by sending in late timesheets, incomplete or illegible forms, or neglect of the EMPLOYER or EMPLOYEE to inform the payroll agent of changes in address, etc.

3. Additional Employees or Replacement of Employees

All new **EMPLOYEES** must complete the employment enrollment process before receiving any paychecks. There are no exceptions to this policy.

4. Termination of Employment

The **EMPLOYER** is responsible for termination of employment, and for notifying the case manager and the payroll agent of all changes in the employment status of **EMPLOYEES**. The **EMPLOYER** must complete an “Employee Action Notice” form and submit to ARIS each time an **EMPLOYEE** terminates employment.

5. Instructions for Completing Timesheets

All timesheets shall be completed with the following information. **All items must be legible!**

- Print **EMPLOYEE** name and social security number on the top corner of timesheet.
- Print the waiver participants name under “consumer” at the top of the timesheet.
- Print the surrogate **EMPLOYER’S** name, if applicable, under “surrogate” at the top of the timesheet.
- Print the last day of the pay period under “Pay Period End Date”. (refer to payroll schedule if needed)
- Enter the date worked in the “Date” column.
- Enter the daily work start time in the “In” column and work stop time in the “Out” column. **Note: If the employee lives with the waiver participant, they may write “Live-in” in place of “in” and “out” times.**
- Enter the total hours of Personal Care worked in decimal format (in 15-minute units) in the “Personal Care Hours” column for each day worked.
- Enter the total hours of Respite Care worked in decimal format (in 15-minute units) in the “Personal Care Hours” column for each day worked.
- Enter the total hours of Companion Care worked in decimal format (in 15-minute units) in the “Personal Care Hours” column for each day worked.
- Add the total Personal Care hours worked for week one and week two. Write the total hours in the “Personal Care Hours” box next to “Total Hours per Service for this Pay Period”.

- Add the total Respite Care hours worked for week one and week two. Write the total hours in the “Respite Care Hours” box next to “Total Hours per Service for this Pay Period”.
- Add the total Companion Care hours worked for week one and week two. Write the total hours in the “Companion Care Hours” box next to “Total Hours per Service for this Pay Period”.
- The **EMPLOYEE** must sign and date at the bottom above “Employee Signature” and “Date”.
- The **EMPLOYER** must sign and date the bottom above “Consumer/Surrogate Signature” and “Date”.

Example of hours entered in decimal format:

one hour: 1.0
 two hours: 2.0
 two hours and 15 minutes: 2.25
 three hours and 30 minutes: 3.5
 three hours and 45 minutes: 3.75

6. Approved Service

The total number of hours for ***all employees combined*** must **not** exceed the authorized number of hours for any services as shown on the individual’s approved Service Plan.

7. Changes in Hours

The **EMPLOYER** should contact the case manager directly to review the need for changes in approved services. A written Service Plan change must be submitted and approved by DAIL **before** any increased service hours will be paid. **Approved changes will be effective the next payroll period after the request is received at DAIL, starting on a Sunday.**

8. Mailing Timesheets

Mail the timesheet to the payroll agent at the address at the bottom of the timesheet. The timesheet must be mailed to the payroll agent so that it reaches the payroll agent’s office by Monday morning following the end of a pay period.

If more than one **EMPLOYEE** works for a participant during the same pay period, the **EMPLOYER** must submit all employee timesheets for this pay period to the payroll agent at the same time.

9. Timesheet Errors

On occasion it may be necessary for ARIS to return timesheets to **EMPLOYERS**. This may result in employee's paychecks being delayed. ARIS is unable to process *any* timesheet that does not have the original signatures of both the **EMPLOYER** and the **EMPLOYEE**. Timesheets will be returned to the employer when the following information is missing or incorrect:

1. Absence of employee name
2. Absence of consumer name
3. Absence of employee signature
4. Absence of employer signature
5. Signature of anyone other than the employer of record on the employer signature line.
6. Absence of dates of service.
7. Two consumers listed for services on one timesheet. Employees must fill out one time sheet per pay period for each consumer they provide care for.

Should a timesheet be returned to the **EMPLOYER** for one of the above reasons, the **EMPLOYER** must complete or correct the identified error, and re-submit the timesheet to ARIS. The timesheet will be processed and paid in the next pay period following receipt in the ARIS Office.

10. Other Reasons an Employee may not get Paid

Other reasons an **EMPLOYEE** may not get paid:

1. Late time sheets. Time sheets must be received in the ARIS office **no later than Monday** of each pay week, according to the Payroll Schedule.
2. Lack of, or incomplete Employer enrollment forms.
3. Lack of, or incomplete Employee enrollment forms.
4. Lack of patient share payment (when a patient share has been determined)
5. Lack of a Department of Disabilities, Aging and Independent Living (DAIL) authorized Service Plan

11. Pay Schedule

Paychecks will be generated by the payroll agent every two (2) weeks, according to the payroll schedule.

12. Pay Rate

As of **July 12, 2009 EMPLOYEES** who are paid through Consumer or Surrogate Directed Services option will be paid:

- \$10.14/hour Personal Care Services
- \$8.62/hour for Respite Care Services
- \$8.62/hour for Companion Services

Note: Workers are **not** paid overtime wages or benefits. The Medicaid rate identified on the Service Plan is higher than the **EMPLOYEE'S** wages because it includes worker's compensation and unemployment insurance that is covered by the state.

13. Patient Share

Under Long-Term Care Medicaid financial eligibility rules, some individuals must pay a monthly patient share payment to cover some of the costs of services. The amount of the patient share, if any, is determined by the Department for Children and Families (DCF). DCF will send a written notice to the individual explaining the amount (if any) of the required patient share. If the individual has a patient share, then:

- The patient share must be paid directly to ARIS each month in the amount indicated on the DCF notice of decision.
- The **EMPLOYER** must pay the monthly patient share in full with the timesheet of the first pay period of the month.
- Timesheets will not be processed, nor can payments to **EMPLOYEES** be made, unless the required patient share payment is submitted to the payroll agent.
- If the required patient share payment is not submitted to the payroll agent, the participant may be terminated from Consumer/Surrogate Directed Services.

Questions regarding Patient Share:

If there are questions about the **amount** of a patient share, contact the CFC case manager or the local District Office of the Department for Children and Families (see Appendix A).

14. Unemployment Benefits

Every **EMPLOYEE** is eligible for unemployment benefits if work hours become unavailable or decrease. If you have questions about unemployment compensation coverage, or about submitting a claim, contact the payroll agent.

15. Workers' Compensation

Every **EMPLOYEE** is covered by workers' compensation insurance. If you have questions about workers' compensation coverage, or about submitting a claim, contact the payroll agent.

16. Taxes

Payments made to every **EMPLOYEE** are treated as earned income, and are taxed as earned income. The payroll agent processes payroll taxes, withholds taxes from wages and prepares annual W-2 tax withholding statements.

17. Problems with the Payroll Agent

EMPLOYERS and **EMPLOYEES** should first attempt to resolve payroll problems by directly contacting the payroll agent. If problems can not be solved, the **EMPLOYER** or **EMPLOYEE** may contact the case manager for assistance. Finally, if problems are still not solved with the help of the case manager, contact DAIL at (802) 241-1228.

18. Medicaid Fraud

Medicaid fraud is committed when an **EMPLOYER** or **EMPLOYEE** is untruthful regarding Choices for Care (CFC) services provided, in order to obtain improper payment. The Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office investigates and prosecutes people who commit fraud against the CFC program. Medicaid fraud is a felony and conviction can lead to substantial penalties (including but not limited to, imprisonment up to ten years, or a fine up to \$1,000 or an amount equal to twice the amount of the assistance or benefits wrongfully obtained, or both). Additionally, individuals convicted of Medicaid fraud will be excluded for a minimum of five years from any employment with a program or facility receiving Medicaid funding.

Examples of Medicaid fraud include:

- Submitting timesheets for services not actually provided (e.g. signing or submitting a timesheet for services which were not actually provided)
- Submitting timesheets for services provided by a different person (e.g. signing or submitting a timesheet for services provided by a different person)
- Submitting twice for the same service (e.g. signing or submitting a timesheet for services which were reimbursed by another source, or signing or submitting a duplicate timesheet for reimbursement from the same source)

Suspected cases of fraud will be referred to the Attorney General's Medicaid Fraud Control Unit and may be referred to the local police authorities for further investigation and possible prosecution.

CHAPTER IX: Case Management Services

Case Management services are provided to all individuals receiving Choices for Care (CFC) in the home-based setting. The case manager is responsible for certifying **EMPLOYERS** and monitoring the services and the health and welfare of individuals participating on the CFC program.

1. Case Manager Responsibilities

The case manager must visit the individual on a regular basis, not less than once every 30 days.

Case managers are responsible for:

- Answering questions about the CFC program
- Assisting individuals in gaining access to needed services
- Overseeing the assessment and reassessment of the individual
- Developing a service plan for the individual
- Monitoring the services included in an individual's service plan
- Assessing the adequacy of care being provided
- Certifying the ability of a consumer or surrogate employer to manage services
- Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services (see Chapter X)
- Reporting suspected cases of Medicaid Fraud to the State (see Chapter VIII)

2. Case Manager Limitations

Case Managers are **not** responsible for:

- Completing or processing payroll forms
- Payroll documentation and submission
- Hiring, firing and training employees

An individual's case manager can provide some *advisory* assistance with these activities, but the **EMPLOYER** is ultimately responsible for all employment issues concerning the **EMPLOYEES**.

CHAPTER X: Abuse, Neglect, and Exploitation

The State of Vermont requires, by law (Title 33, VT Statue), that all health professionals report cases of suspected adult abuse, neglect, and exploitation. Those who are “mandated” to report such cases include, but are not limited to:

- Case Managers,
- Personal Care Attendants,
- Respite Care Workers,
- Companion Workers,
- Home Health Agency Employees,
- Adult Day Employees,
- Hospital Employees,
- Social Workers,
- Physicians, and
- Payroll Agent (ARIS)

Other concerned individuals may also report suspected adult abuse, neglect, or exploitation. In most cases, the identity of the individual making the report shall remain confidential.

Reports are made by contacting the Vermont Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, Adult Protective Services (APS) at 1-800-564-1612.

Appendix: Local Agencies

1. Department of Disabilities, Aging and Independent Living

District Office	Phone	Fax
Barre	(802) 476-1646	(802) 476-1654
Bennington	(802) 447-2850	(802) 447-6972
Brattleboro	(802) 251-2118	(802) 254-6394
Burlington	(802) 879-5904	(802) 879-5620
Hartford	(802) 296-5592	(802) 295-4148
Middlebury	(802) 388-5730	(802) 388-4637
Morrisville	(802) 888-0510	(802) 888-0536
Newport	(802) 334-3910	(802) 334-3386
Rutland	(802) 786-5971	(802) 786-5882
Springfield	(802) 885-8875	(802) 885-8879
St. Albans	(802) 524-7913	(802) 527-4078
St. Johnsbury	(802) 748-8361	(802) 751-2644
Waterbury Central Office	(802) 241-1228	(802) 241-4224

2. Local Area Agencies on Aging

Champlain Valley Agency on Aging	(802) 865-0360
Northeastern VT Area Agency on Aging	(802) 748-5182
Central VT Council on Aging	(802) 479-0531
Southwestern VT Council on Aging: Bennington Rutland	(802) 442-5436 (802) 786-5991
Southeastern VT Council on Aging	(802) 885-2655

3. Local Home Health Agencies

Addison County Home Health & Hospice	(802) 388-7259
Bennington Area Home Health	(802) 442-5502
Caledonia Home Health	(802) 748-8116
Central VT Home Health	(802) 223-1878
Chittenden / Grand Isle Visiting Nurse Association	(802) 658-1900 (TDD) or (800) 833-6111
Franklin County Home Health Agency	(802) 527-7531
Lamoille Home Health	(802) 888-4651
Manchester Health Services	(802) 362-2126
Orleans / Essex Visiting Nurse Association	(802) 334-5213
Rutland Area Visiting Nurse Association	(802) 775-0568
Visiting Nurse Alliance of VT & NH	(800) 858-1696

4. DCF District Offices (Financial Eligibility)

Barre	(802) 479-1041 or 800 499-0113
Bennington	(802) 442-8541 or 800 775-0527
Brattleboro	(802) 257-2820 or 800 775-0515
Burlington	(802) 863-7365 or 800 775-0506
Hartford	(802) 295-8855 or 800 775-0507
Middlebury	(802) 388-3146 or 800 244-2035
Newport	(802) 334-6504 or 800 775-0526
Rutland	(802) 786-5800 or 800 775-0516
Springfield	(802) 886-3551 or 800 589-5775
St. Albans	(802) 524-7900 or 800 660-4513
St. Johnsbury	(802) 748-5193 or 800 775-0514

APPENDIX B
DRAFT MDS 3.0 SECTION Q PROTOCOL AND REFERRAL FORM

Vermont ADRC Proposal for Implementing “Nursing Home Transitions” Section Q of the MDS 3.0

Context:

Important progress has been made in the last 20 years so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. Legislation such as the Americans with Disabilities Act (1990) and the Olmstead Supreme Court Decision (1999) have led to outcomes from various long-term care rebalancing initiatives, including grant and demonstration programs funded by CMS.

On October 1, 2010, changes to the MDS 2.0 will be implemented per CMS requirements. The new MDS 3.0 will become the new assessment tool used in all nursing facilities, including significant changes to Section Q. What does Section Q do?

- Broadens the traditional definition of “discharge planning” in nursing homes.
- Recognizes that an expansive range of community-based supports and services are necessary for successful community-living.
- Encourages nursing home interdisciplinary staff to assess long stay residents who may not have been previously considered as candidates for community living.
- Facilitates resident and nursing facility connection and communication with local contact agency experts to assess community resource availability and determine whether community discharge is possible.
- Meaningfully engages residents in their discharge planning goals.
- Directly asks the resident if they want information about long-term care community options.
- Promotes linkages and information exchange between nursing homes, local contact agencies, and community-based long-term care providers.
- Promotes discharge planning collaboration between nursing homes and local contact agencies for residents who may require medical and supportive services to return to the community.

New Expectations:

- The appropriate State agency (in VT, DLP) is expected to identify “Local Contact Agencies”.
- Nursing home staff are expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.
- Local Contact Agencies are expected to respond to nursing home staff referrals by providing information to residents about available community-based long-term care supports and services.
- Nursing home staff and Local Contact Agencies are expected to meaningfully engage the resident in their discharge and transition plan and collaboratively work to arrange for all of the necessary community-based long-term care services.
- State Medicaid Agencies will have to amend their Data Use Agreement (DUA) with CMS to share MDS data with the organization(s) that they create agreements with and designate to provide information to individuals about community and HCBS options. A DUA is not required to refer a resident to speak to someone about return to community.

Implementation Strategy:

- The statewide Aging and Disability Resource Connection (ADRC) will serve as the umbrella coordinator for the Local Contact Agencies (LCAs)
- The following ADRC partner agencies are identified as the LCAs:
 - 5 Area Agencies on Aging
 - Vermont Center for Independent Living
 - Brain Injury Association of Vermont
- Procedural Operations and Flow Chart (next page)

1) Initial Referral

Nursing facility, through Section Q, identifies individual wanting to speak with someone about the possibility of returning to the community

- a. **Individual age 60 or over** ^{Referred to} → **Area Agency on Aging via Senior Helpline -- 1-800- 642-5119**

i. For calls coming to CVAA as the default for out-of-state referrals:

1. CVAA will determine where individual resides and will make referral to appropriate AAA, VCIL, or BIAVT based upon answers to standard basic questions below

- b. **Individual under age 60** ^{Referred to} → **Vermont Center for Independent Living I-Line 1-800-639-1522**

i. VCIL will make referral, as appropriate based upon answers to standards basic questions, to BIAVT or other agency to model “team approach” to follow up.

- c. CVAA and/or VCIL will ask nursing facility staff a series of questions to determine appropriate follow-up:

- i. How is the individual’s stay in the NH being paid for? (Medicaid—if on Medicaid is on Choices for Care, Medicare, private insurance, private pay)
- ii. Is the individual on Choices for Care? If yes....
- iii. Does the individual already have a case manager associated with one of the partner agencies or a Home Health Agency? If yes....
 1. If the case manager is from a home health agency, referral to ADRC partner agency must also include involvement of HHA case manager in follow-up

2) Follow Up

Based upon answers to standard basic questions, CVAA and VCIL will make referral to any of the other ADRC partner agencies (other AAAs, VCIL or BIAVT) for follow up, and to the HHA case manager if the individual is on CFC and has a HHA case manager already identified.

- a. For border facilities (NH, MA, NY), the LCA (AAA, VCIL, or BIAVT) that serves that area will conduct the first follow up contact and determine whether the individual is truly a candidate for transition. If so, that agency will then refer the individual to the appropriate partner agency serving the town of residence where the individual resides or will return “home”.
- b. At a minimum, a phone contact is made with the individual to initiate a conversation about the possibility of returning to the community. Per CMS, *the designated LCA should follow up about the resident’s request within 10 business days of a yes response being given on Section Q. This is a recommendation however, and not a requirement. Follow-up is expected in a “reasonable” amount of time. We would expect a reasonable contact response time on the part of the LCA of within 3 days by phone and within 10 days if an on-site visit is needed. States may establish their own process to monitor performance.*
- c. *Per CMS, a referral to the LCA should be made if the resident wishes, even if they have a legal guardian, durable power of attorney for health care or a legally authorized representative, in accordance with state law.*
- d. LCA works with individual/surrogate/guardian/family and nursing facility to discuss options and build a transition plan, if it is feasible. Per CMS, *the level and type of response needed by an individual is determined on a resident-by-resident basis and is to be part of the State’s design for Section Q implementation.*
- e. *Per CMS, the skilled nursing facilities and nursing facilities and LCAs must explore community care options and conduct appropriate care planning together to develop an array of supports for assisting the resident if transition back to the community is possible.*
- f. If individual is on Choices for Care, once options are discussed and person chooses Choices for Care community options, involvement of LTCCC will facilitate logistics—choice of case manager, etc.
 - i. If individual is on Choices for Care, the appropriate LCA must determine if the individual has already selected a case manager. If so, that case manager must be informed and involved in the transition discussions.
- g. If individual is private pay, discussion and selection of options, and development of transition plan would occur with support of LCA.
- h. Of note—there may be instances where a “team approach” is the optimal approach. For example, an elder with a TBI. In these circumstances, the LCAs working collaboratively to assist the individual are desirable.

Outstanding Questions:

1) What should the role of ombudsmen be? See answer below from CMS Q&A:

The long-term care ombudsman is available to assist nursing home residents by resolving complaints related to the transitions process, as well as by providing information and education to consumers, facility staff, and the general public regarding the transitions process. However, the coordination of services is not a typical Ombudsman role. Possible major activities might include: 1) investigation and resolution of resident complaints about transitions to the community, 2) supporting residents in their decision-making related to transitions, 3) providing information to consumers and providers

(i.e. consultation to individuals) about residents rights and options, 4) providing educational sessions and materials to consumers and the general public about resident rights and options, and 5) Helping to identify candidates for transitioning to community living and making referrals as appropriate.

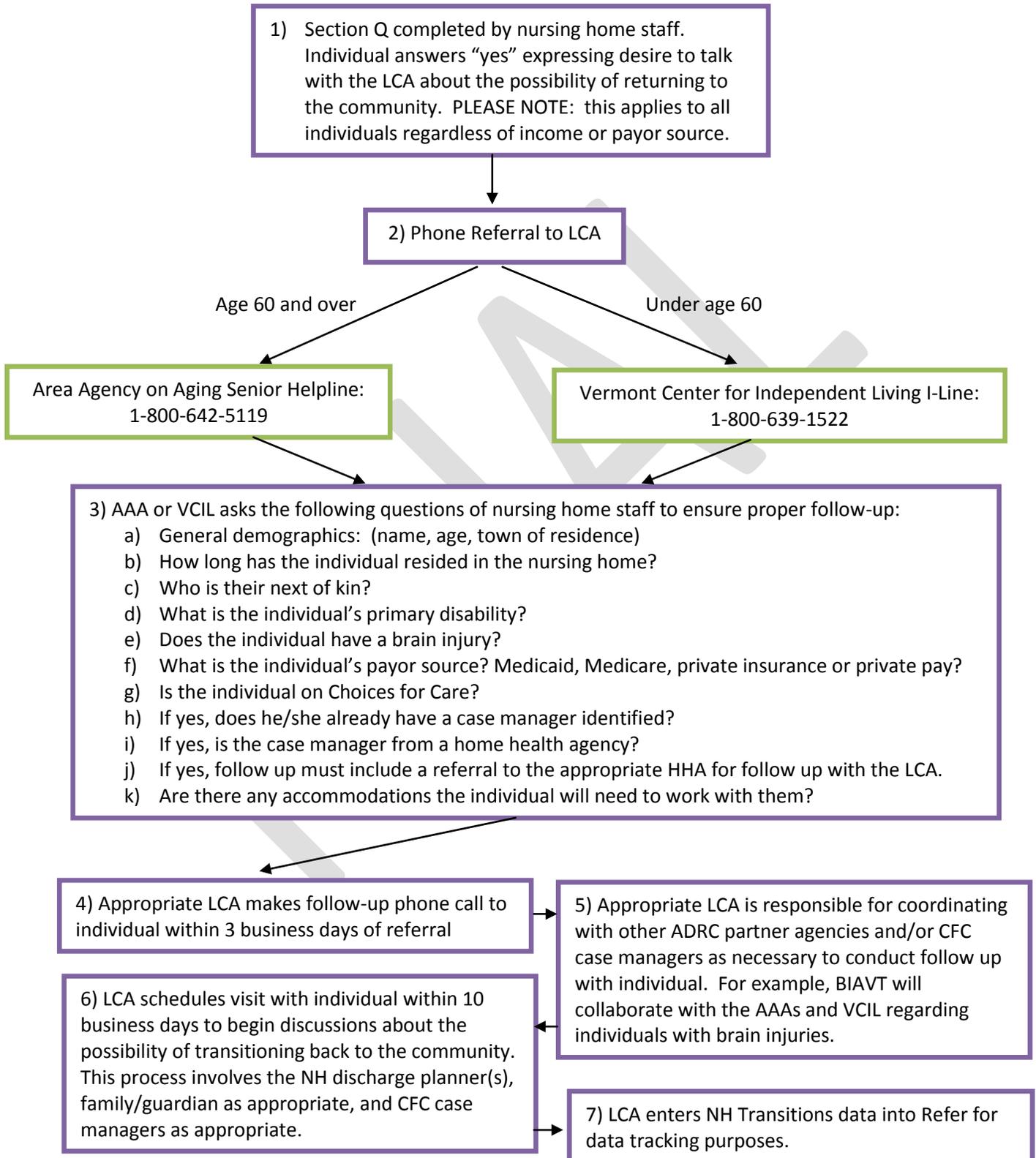
2) Who will ensure Data Use Agreement is in place and what information does it cover? See answer below from CMS Q&A:

In order for the local contact agencies to receive Minimum Data Set (MDS) data (i.e. a list of names of individuals from the MDS data set who answered, "Yes, I would like to speak to someone about the possibility of returning to the community" for each nursing facility), States will need a revised Data Use Agreement. CMS is asking State Medicaid agencies to amend their Medicaid MDS Data Use Agreements to include designated local contact/referral agencies if this is the case. The Medicaid Data Use Agreement must be amended to include those local contact agency entities to be authorized to obtain individual named referrals from the MDS data base in order to comply with the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) rule. This relationship must be included in the contract or memorandum of understanding between the Medicaid agency and the local contract agency (LCAs).

The Medicaid Agency's Data Use Agreement *applies to all nursing facility residents included in the MDS data base.*

See flow chart on next page.

“Nursing Home Transitions” Flowchart



Nursing Home
MDS 3.0 Section Q Referral

Date of Referral

I. Nursing Home			
Name - Facility	Local Contact Agency (LCA) Name		
NF Staff Contact(s)	LCA Staff Contact(s)		
NF Phone Number	LCA Phone Number		
NF Fax Number	LCA Fax Number		
II. Resident Being Referred			
Name- Resident	Room Number	Date of Birth	
Telephone Number to Reach Resident		County of Residence Prior to Admission	
<input type="checkbox"/> Yes <input type="checkbox"/> No Does this resident have a legal guardian?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Does this resident have an enacted Durable Power of Attorney			
Name – Legal Guardian/Enacted Durable Power of Attorney			Telephone Number
Individual’s Payer Source (<i>Check all that apply</i>)			
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> PACE <input type="checkbox"/> Private Insurance <input type="checkbox"/> Private Pay <input type="checkbox"/> Other			
III. Authorized Representative (if applicable)			
Name-Representative		Telephone number	
Mailing Address- Street	City	State	Zip Code
Individual’s Preferred Contact: <input type="checkbox"/> Self <input type="checkbox"/> Other Name:		Relationship	
IV. Signature (Optional)			

Signature – Resident or Resident’s Legal Representative

Date Signed

- Submit a completed copy of this form to the local contact agency (ADRCs) serving in the county in which the nursing home is located within ten (10) business days of completing Section Q of the MDS. Do NOT submit it to the resident’s county or residence.
- Keep a copy of the referral form in the resident’s medical record

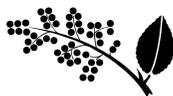
APPENDIX C
CHOICES FOR CARE PARTICIPANT HANDBOOK

Choices for Care

Vermont Long-Term Care

Participant Handbook

June 2009



This information is important. If you do not understand it, take it to your local office for help.

Ces informations sont importantes. Si vous ne les comprenez pas, apportez-les à votre bureau local pour recevoir de l'aide. **French**

Это важная информация. Если она Вам непонятна, возьмите это письмо и обратитесь за помощью в местное отделение. **Russian**

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. **Serbo-Croatian**

Esta información es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda. **Spanish**

Maelezo ya barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi. **Swahili**

Thoâng tin naøy raát quan troing. Neáu quyù vò khoâng hieâu noãi dung trong ñoù, haøy ñem thõ naøy ñeán vaên phoøng taï ñòa phõøng cuõa quyù vò ñeã ñõõic giuùp ñõõ. **Vietnamese**

Vermont Agency of Human Services
 Department of Disabilities, Aging and Independent Living
 Division of Disability and Aging Services
 103 South Main Street – Weeks 2
 Waterbury, Vermont 05671-1601
 802-241-1228 (voice/ttd)
www.dail.vermont.gov

Your Case Manager or Program Contact: _____

Phone: _____

This document is available in alternative format upon request.



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CHAPTER I: Introduction

Welcome! You have chosen the Vermont Choices for Care Medicaid Waiver (CFC) program to help provide your long-term care services. The Department of Disabilities, Aging and Independent Living (DAIL), Division of Disability and Aging Services (DDAS) manages the **Choices for Care** (CFC) program. It was created to help Vermont elders and adults with physical disabilities pay for long-term care services in the setting of their choice.

This Participant Handbook was created to:

- Help you understand the program,
- Help you understand your rights and responsibilities in the program,
- Help you understand provider rights and responsibilities,
- And help you know who to contact when you need assistance.

Where can you receive Choices for Care services?

1. In your home or the home of another person, or
2. In an approved Residential Care Home or Assisted Living Residence, or
3. In an approved Nursing Facility.

This Participant Handbook will tell you more about what is available and the limitations under each **Choices for Care** option.

Where can you get more information?

For more information about the **Choices for Care** program you may:

- Contact your case manager or program contact written on the front of this handbook.
- Contact the provider of your services or the local Long-Term Care Clinical Coordinator (LTCCC) listed in the back of this handbook.
- Contact a VT Long-Term Care Ombudsman listed in the back of this handbook.
- Contact the Division of Disability and Aging Services (DDAS) at (802) 241-1228 or find information online at <http://www.ddas.vermont.gov/>.
- For financial eligibility information, contact the Department for Children and Families (DCF), Economic Services Division (ESD) listed in the back of this handbook.



CHAPTER II: Eligibility

What are the eligibility criteria for Choices for Care?

To be eligible, you must:

- a) be a Vermont resident;
- b) be at least 18 years old (55 or older for the PACE option);
- c) meet the clinical criteria (nursing home level of care);
- d) be financially eligible for Vermont Long-Term Care Medicaid.

NOTE: Individuals who want to manage their own services at home must also meet all EMPLOYER eligibility guidelines.

Once you are on the program, your eligibility will be reviewed on a regular basis (at least once a year) to make sure you continue to meet all of the eligibility criteria.

What are the clinical eligibility criteria?

The clinical eligibility criteria for the Choices for Care program is the same as “**nursing home level of care**”. To make sure you meet these clinical criteria, a Long-Term Care Clinical Coordinator (LTCCC) nurse assesses your abilities and the help you need with things such as:

- Activities of Daily Living - how you manage day-to-day with activities like dressing, bathing, walking, and using the bathroom
- Cognition - how you remember and use information
- Medical conditions and treatments

Once you are on the program, your clinical eligibility will be reassessed at least once a year. If your health and care needs improve and you no longer need nursing home level of care, you will receive a notice letting you know you are no longer eligible for the program. The notice will also explain your appeal rights.

What is the financial eligibility criteria?

To be eligible for Choices for Care you must meet all Long-Term Care Medicaid financial criteria. To determine financial eligibility, your local Department for Children and Families (DCF), Economic Services Division (ESD) looks at your income, assets and whether you gave away assets such as money or real estate. While you are on the program, ESD will send you financial review forms once every 6-12 months. You must complete and return the review forms timely so ESD can review your eligibility for Long-Term Care Medicaid and continue your participation on the program. ***If you do not complete and return your review forms, your Medicaid eligibility will be closed and you will be terminated from the program, including all of your Choices for Care program services.***

If at any time you are found ineligible for Long-Term Care Medicaid, you will receive a notice from DCF. The notice will also explain your appeal rights.

NOTE: While you are on the program, you must report certain changes to DCF as described in your DCF financial eligibility notice.



CHAPTER III: Program Options

For more information and service limitations, go online to the Choices for Care Program Manual at <http://www.ddas.vermont.gov/>. These services are not intended to replace other Medicare, Medicaid or health insurance covered services you may already be receiving or are eligible to receive.

How can you receive care in your own home or the home of another person?

A. Home-Based Services:

If you would like to have a choice of multiple services while living in your own home or the home of another person, you may be interested in this option. The home-based option uses case management services to help you create a plan for services which is based on your abilities and needs. Case management services are provided by either your local Area Agency on Aging or approved Home Health Agency.

→ Services Include:

1. Case Management –assists in obtaining, coordinating and monitoring services
2. Personal Care –assists with activities of daily living such as dressing, toileting and transferring.
3. Adult Day – Adult Day centers provide meals, activities, nursing, personal care and supervision.
4. Respite – a break for your unpaid caregiver such as a family member.
5. Companion – read mail, write letters, play cards, social visits, etc.
6. Personal Emergency Response (PERS) – phone line button to call for help.
7. Assistive Devices/Home Modification – such as a ramp to your home or a reacher-grabber.

NOTE: The amount of Personal Care Services approved is based on your assessed unmet needs and is limited. Ask your case manager or LTCCC if you have any questions.

There are two ways to manage your home-based Personal Care, Respite Care and Companion Services. Your case manager can help you decide which option best fits your needs. They are:

1. **Agency Directed Services:** If you would like a home health agency to hire, supervise and manage your Personal Care, Respite and Companion Services, you may be interested in the Agency Directed option. With this option, scheduling of your care is based on the type of care that you need as identified in a service plan and the agency's availability of staff. If you have any questions or concerns regarding staffing of your care, please contact your local home health agency listed in the back of this handbook.

2. **Consumer/Surrogate Directed Services**: If you or a trusted person (surrogate) you know living nearby, are able and willing to hire, supervise and manage your own caregivers, you may be eligible under the Consumer or Surrogate Directed option. This option gives you more control over who you hire and how you schedule your care. You or your surrogate becomes the “employer”. Speak with your case manager if you are interested in this option.

B. **Flexible Choices**: Flexible Choices is the home-based option that offers you the most flexibility and control of your care plan. While Flexible Choices expects a lot of you, it gives you the opportunity to design your care in the way that best meets your needs. To be eligible for this option, you must be able to supervise and manage your own care and services or have an eligible surrogate who can do it for you.

Flexible Choices approves a monthly **allowance**, which is based on your assessed needs. Working with a **Flexible Choices consultant**, you develop a **budget** for how you will spend that allowance in a way that best meets your needs. Case management services are only available if you decide to include it in your budget. However, if you chose to pay your spouse to provide personal care, you must include a certain amount of case management in your budget.

In your budget you can decide:

- **How much you want to pay** your caregivers,
- To **save up** unspent amounts from the allowance from week to week to use when you really need them,
- To **purchase things** to keep you healthy and independent,
- To have a **small amount of cash** to pay for things like shoveling your walk or paying for rides to the store.

NOTE: The amount of your approved Flexible Choices allowance is based on your assessed needs and is limited. Ask your Flexible Choices consultant or LTCCC if you have any questions.

C. **Program for All Inclusive Care for the Elderly (PACE)**: PACE is a program that combines your Medicare and/or Medicaid benefit so that the PACE organization can arrange for and provide all of your health care services. The following additional eligibility criteria apply:

- You must be at least 55 years old ,
- You must live in one of the following areas:
 - Chittenden County or the towns of South Hero or Grand Isle.
 - Rutland County or the towns of Dorset, Rupert or Manchester.
- You must be able to live safely in the community with services from PACE.

You must agree to use the PACE physician as your primary physician.

→ The PACE benefit package includes, but is not limited to:

1. Interdisciplinary team assessment and treatment planning,
2. Primary care services including physician and nursing services,
3. Social work services,
4. Restorative therapies, including physical therapy, occupational therapy and speech-language pathology,
5. Medications delivered to your home,
6. Personal care and supportive services,
7. Nutritional counseling,
8. Recreational therapy,
9. Transportation to appointments,
10. Meals at the PACE site,
11. Medical specialty services,
12. Laboratory tests, x-rays and other diagnostic procedures,
13. Drugs and biologicals,
14. Prosthetics and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance for these items,
15. Acute inpatient care,
16. Nursing facility care.

What services can you receive in a Residential Care Home or Assisted Living Residence?

If you would like to live in a Residential Care Home or Assisted Living Residence where you can receive care and supervision 24 hours per day, you may be interested in the “Enhanced Residential Care” (ERC) option. In ERC, Medicaid pays a daily rate to eligible VT Licensed Residential Care Homes and Assisted Living Residences to provide you with a package of services. You pay the home for your room and board. Case management services are also provided through your choices of the local Area Agency on Aging or approved Home Health Agency. A list of ERC providers can be found online at <http://www.dail.state.vt.us/lp/> or by calling (802) 241-2345.

→ Services include:

1. Nursing Overview & Assessment
2. Personal Care Service
3. Medication Management
4. Recreation Activities
5. 24-Hour On-Site Supervision
6. Laundry Services

7. Household Services
8. Documentation
9. Case Management Services (from the local Home Health Agency or Area Agency on Aging)

NOTE: You will be responsible to pay the ERC Provider for the cost of your room & board.

What services can you receive in a Nursing Facility?

If you would like to live in a Nursing Facility that provides a wide array of health, medical, therapeutic and personal care services 24 hours per day, you may be interested in the Nursing Facility option. This option pays a VT Licensed Nursing Facility a daily rate to provide you with a package of long-term care and skilled nursing/rehabilitation services. A list of nursing facilities can be found online at <http://www.dail.state.vt.us/lp/> or by calling (802) 241-2345.

→ Services include:

1. Room and Board
2. Skilled Nursing & Assessment
3. Personal Care
4. Medication Management and Pharmacy Services
5. Social Worker Services & Recreation Activities
6. 24-Hour On-Site Nursing Care and Supervision
7. Laundry Services
8. Housekeeping Services
9. Transportation Services
10. Physical Therapy, Occupational Therapy and Speech Therapy
11. Nutritional and Dietary Services
12. Maintenance of Resident Clinical Records

NOTE: Nursing facility services may also be available to you on a short-term basis to recover from an illness or injury, under your Medicare or other health insurance benefit.



CHAPTER IV: Program Limitations

There are some important program limitations that you should know about. If you need more information, please speak with your case manager, provider agency or go online to the Choices for Care program manual at: <http://www.ddas.vermont.gov/>.

What are the eligibility limitations?

1. Individuals whose need for services is due to mental retardation, autism, or mental illness are not eligible for Choices for Care.
2. Choices for Care will 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 private insurance, Medicare, Medicaid, Veterans health benefits, or another Medicaid Waiver program.
3. If your income is more than the Long-Term Care Medicaid income standard, you may have to pay some of the cost of your services every month. This is called a patient share. If you have a patient share, your notice from DCF/ESD will say how much it is and who to pay it to. Contact DCF if you have any questions about your patient share.

What are the program limitations?

All Choices for Care services are subject to certain limitations. Refer to the Program Manual or ask your case manager, provider of services or local LTCCC for detailed service limitations. Here is a list of important limitations that apply to all CFC services:

1. The Choices for Care regulations require that services be provided in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks. In some cases, a Home-Based plan may be adjusted if the volume of care is deemed unnecessary or is being duplicated by another service.
2. CFC only provides services and care for the individual who has been found eligible. Therefore, services are **restricted to the benefit of the individual**.
3. CFC shall not be used to provide services that are otherwise being purchased privately or through another funding source.
4. CFC services shall not be furnished to individuals who are inpatients of a hospital facility for an acute medical stay (except in the PACE option which pays for all necessary health care services).
5. An individual's legal guardian (appointed by a probate court) shall not be paid to provide services under CFC.

6. Individuals who are absent from the state of Vermont for more than 30 days will be terminated from the program.
7. Individuals are not eligible to be on both Choices for Care in addition to another program that provides similar services, such as the Attendant Services Program, Hospice Program, the Developmental Services Waiver and the Traumatic Brain Injury program.
8. Persons with any of the following may not be paid to provide services under the CFC program (*DAIL Background Check Policy, April 1, 2006*):
 - a. a substantiated history of abuse, neglect, or exploitation of an adult or child;
 - b. exclusion from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General; or
 - c. a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust.

What are some other limitations in the Home-Based option?

1. Case Management is limited to 48 hours per calendar year.
2. The amount of Personal Care Services is limited to the assessed need of the individual. The amount of approved hours is subject to review and approval by the Long-Term Care Clinical Coordinator.
3. Respite and companion services are limited to 720 hours per calendar year (total/combined).
4. Assistive device and home modifications are limited to \$750 per calendar year. Some items are automatically approved, some items need pre-authorization and some items are never allowed. Check with your case manager. If you are on Flexible Choices, check with your consultant about limitations for assistive devices and home modifications.
5. Your spouse can not be paid by CFC to provide assistance with any Instrumental Activities of Daily Living (meal prep, medication assistance, housekeeping, shopping, laundry, transportation, etc), companion or respite services. Other restrictions apply. ***Please check with your case manager or consultant before requesting your spouse to be a paid caregiver.***
6. Though some individuals may choose to hire friends or family to be paid by CFC, please note that CFC is not an employment program.
7. Individuals who wish to be a certified employer for consumer or surrogate directed services must be certified by the case manager or consultant. Employer certification is reviewed annually and is subject to change. ***For more information, ask your case manager, consultant or payroll agent for an Employer Handbook.***

What is Medicaid Fraud?

Medicaid fraud is when an **EMPLOYER** or **EMPLOYEE** is untruthful regarding Choices for Care (CFC) services provided, in order to obtain improper payment. It is also considered Medicaid fraud when an individual knowingly gives false, incorrect, incomplete, or misleading information in order to be eligible for Long-Term Care Medicaid.

The Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office investigates and prosecutes people who commit Medicaid fraud. Medicaid fraud is a felony and conviction can lead to substantial penalties (including but not limited to, imprisonment up to ten years, or a fine up to \$1,000 or an amount equal to twice the amount of the assistance or benefits wrongfully obtained, or both). Additionally, individuals convicted of Medicaid fraud will be excluded for a minimum of five years from any employment with a program or facility receiving Medicaid funding.

Some examples of Medicaid fraud include:

- Submitting timesheets for services not actually provided
- Submitting timesheets for services provided by a different person
- Misrepresenting your needs.
- Not telling the Department for Children and Families (DCF) about assets you own that are counted in financial eligibility. (e.g. property you own in a another state or a bank account with your name on it)

NOTE: Suspected cases of fraud will be referred to the Attorney General's Medicaid Fraud Control Unit and may be referred to the local police authorities for further investigation and possible prosecution. If you suspect Medicaid Fraud, contact the Attorney General's office at (802) 241-4440.



CHAPTER V: Your Rights

What are your rights on this program?

As a participant of the Choices for Care program, you have the following rights:

1. You have a right to be treated with dignity and respect.
2. You have a right to information.
3. You have a right to privacy.
4. You have a right to participate in the development and implementation of your services.
5. You or your legal guardian, have a right to make your own decisions.
6. You have a right to appeal adverse decisions made by the state.
7. You have a right to make a complaint when you are not happy with the services you are receiving.
8. You have a right to receive competent, considerate, respectful care from Choices for Care providers.
9. You have a right to withdraw from the program at any time.



CHAPTER VI: Your Responsibilities

What are your responsibilities on this program?

As a program participant, you have a very important role in the Choices for Care program. Here are some of your key responsibilities as a participant of this program:

1. Participate fully in your assessment and care plan process.
2. Provide complete and accurate information.
3. Keep appointments with your providers of care. Let them know ahead of time when an appointment can not be kept.
4. Authorize the LTCCC, your case manager and providers to obtain necessary records and information regarding your care and program eligibility.
5. Participate in your care as much and as you can. Ask your provider of services if there are ways you can safely become more independent and involved in your care. Ask about assistive devices, durable medical equipment or therapy services.
6. Complete all DCF forms in a timely manner to keep your LTC Medicaid eligibility.
7. Notify DCF within ten (10) days of the change when you have a change in your income, resources, medical expenses, insurance premiums or coverage.
8. Notify your providers and DCF immediately if you have a change of address.
9. Notify your case manager, DCF, and provider of service if you will be out of the state for more than 30 days.
10. Report changes in your care needs and health status to your case manager or provider of services. Let them know when you need more or less help.
11. Help your providers be as efficient as they can.
12. If you are unhappy with your services, ask your case manager or the provider of your service who you can talk to so you can fix the problem.
13. If you receive care at home, develop an emergency backup plan for care and services with your case manager.
14. Pay your patient share on time each month if you have one.
15. Learn as much as you can about the program, what it can offer and what are the limitations.
16. Understand that Choices for Care is funded through Medicaid by the federal and VT state government. Funding is limited, so services provided to you must be as effective and efficient as possible.
17. Provide feedback about the program and your services when you are asked. The only way to improve the program is for providers and the Department to better understand the problems.



CHAPTER VII: Provider Responsibilities

What are the provider responsibilities on this program?

All Choices for Care providers of service must follow program standards. Their key responsibilities to you are:

1. Comply with all applicable provider qualifications, standards and regulations.
2. Ensure that all staff with direct participant contact has passed a background check, according to the DAIL Background Check Policy (April 1, 2006).
3. Provide services according to service principles, definitions, standards, approved activities, and limitations.
4. Provide services in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks.
5. Implement structured internal complaint and appeals procedures.
6. Fully inform individuals of their rights and responsibilities in working with the agency, including both internal and formal complaint and appeal procedures.
7. Encourage and assist the participant to direct as much of her/his own care as possible.
8. Implement policies and procedures that will be used to supervise and/or monitor services.
9. Follow Vermont statute 33 V.S.A. § 6903 regarding mandated reporting of abuse, neglect, and exploitation.
10. Demonstrate to the DAIL that they have sufficient expertise and capacity to meet the needs of the target population, including effective working relationships with other local or regional providers and agencies.
11. Ensure services are provided as defined in the approved CFC Service Plan (when applicable).
12. Ensure that staff has the skills and/or training required to meet the needs of the individual.
13. Maintain accurate and complete documentation of services provided to the individual.
14. Report any concerns about services or the individual's status and condition to the individual's case manager, if the individual is in the home-based or ERC setting.
15. Ensure that the volume of services and rate charged to the State are based on services actually provided to the participant, within the limits specified in the approved Service Plan.
16. Avoid conflicts of interest between the interests of the individual and the interests of the provider and its staff.
17. Assist the State in ensuring that services are provided in compliance with the standards, policies and procedures established by the State. This includes participating in structured evaluation activities developed by the State.
18. Abide by principles of confidentiality and all applicable confidentiality policies and laws.
19. Comply with all applicable laws and regulations regarding employment, including the provision of workers compensation insurance and unemployment insurance to employees.



CHAPTER VIII: Abuse, Neglect, & Exploitation

What is Abuse, Neglect, and Exploitation?

ABUSE - Abuse can be any action (including unnecessary restraint or confinement) that threatens a vulnerable adults' physical or emotional health or welfare. Any sexual activity between a vulnerable adult and a volunteer or paid caregiver employed by a facility of program is also **abuse**. Providing or threatening to provide a drug or other potentially harmful substance to a vulnerable adult for other than lawful and legitimate medical or therapeutic treatment is **abuse**.

NEGLECT- Neglect is the purposeful or reckless failure by a caregiver to provide adequate care (the goods, services and plans needed to maintain reasonable health and safety) to a vulnerable adult. **Neglect** is also the failure of a caregiver to report significant changes in the health of a vulnerable adult or the failure to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others.

EXPLOITATION - **Exploitation** is the willful unauthorized transfer or use of a vulnerable adult's property and includes interest in or control of assets or gain through undue influence or fraud. It is **exploitation** to force or compel a vulnerable adult to perform services for the profit or advantage of another. **Exploitation** also covers any non-consensual sexual activity with a vulnerable adult.

Who is required to report Abuse, Neglect, and Exploitation?

The State of Vermont requires, by law (Title 33, VT Statue), that all health professionals report cases of suspected abuse, neglect, and exploitation of a vulnerable adult to Adult Protective Services. Examples of people who must report are:

- Case Managers,
- Personal Care Attendants,
- Respite Care Workers,
- Companion Workers,
- Home Health Agency Employees,
- Adult Day Employees,
- Residential Care Home & Assisted Living Residence Employees,
- Nursing Facility Employees,
- Hospital Employees,
- Social Workers,
- Physicians, and
- Payroll Agent (ARIS)

Other concerned individuals may also report suspected adult abuse, neglect, or exploitation. In most cases, the identity of the individual making the report shall remain confidential.

Reports are made by contacting the Vermont Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, Adult Protective Services (APS) at 1-800-564-1612 or online at <http://www.dail.state.vt.us/lp/aps.htm>.



Table A: Who to Contact When?

Type of Question or Issue	Contact
Abuse, Neglect, Exploitation.	Adult Protective Services 1-800-564-1612
Appeal a decision made by DAIL.	DAIL 241-2401
Appeal a decision made by DCF.	Local DCF office (see table D. 4)
Clinical eligibility.	Local LTCCC (see table D. 1)
Complaints about the care and services provided by a facility or agency that provides health care.	Division of Licensing and Protection 1-800-564-1612
Financial Eligibility.	Local DCF/ESD (see table D. 4)
General Choices for Care program questions.	Your case manager, provider of care, the local LTCCC or DAIL Waterbury Central Office (see table D.)
Health care and health insurance coverage problems.	VT Office of Health Care Ombudsman 1-800-917-7787
Help to resolve problems regarding Choices for Care denials, quality of care, finding care or services as well as education about long-term care services.	VT Long-Term Care Ombudsman 1-800-889-2047
Help finding caregivers.	Rewarding Work Caregiver Registry: http://www.rewardingwork.org/ or HomeShare VT 802 863-5625 or speak with your case manager.
Home Health Services.	Local Home Health Agency (see table D. 3)
Legal assistance.	VT Legal Aid 1-800-889-2047
Lists of licensed Residential Care Homes, Assisted Living Residences, Nursing Facilities, Home Health Agencies, Hospitals, etc.	Division of Licensing and Protection 1-800-564-1612
Payroll questions for consumer or surrogate directed services.	ARIS Solutions 1-800-798-1658
Peer counseling and assistance for adults with disabilities.	VT Center for Independent Living 1-800-639-1522
Services for Adults 60 years and older.	Local Area Agency on Aging (see table D. 2)



Table B: State Websites

Agency/Department	Website
Department for Children and Families (DCF):	http://www.dcf.vermont.gov/
Department of Disabilities, Aging and Independent Living (DAIL):	http://dail.vermont.gov/
Division of Disabilities and Aging Services (DDAS):	http://www.ddas.vermont.gov/
Division of Licensing and Protection (DLP)	http://www.dail.state.vt.us/lp/
Economic Services Division (ESD):	http://www.dcf.vermont.gov/esd
Office of VT Health Access (OVHA):	http://ovha.vermont.gov/
Other Resources:	http://www.ddas.vermont.gov/ddas-resources



Table C: Publications

Publication	Located
Choices for Care Forms	DAIL: (802) 241-1228 http://www.ddas.vermont.gov/
Choices for Care Policies and Guidelines	DAIL: (802) 241-1228 http://www.ddas.vermont.gov/
Choices for Care Program Manual	DAIL: (802) 241-1228 http://www.ddas.vermont.gov/
Choices for Care Regulations	DAIL: (802) 241-1228 http://dail.vermont.gov/dail-statutes
Home Health Agency Regulations	DLP: (802) 241-2345 http://dail.vermont.gov/dail-statutes
Residential Care Home Regulations	DLP: (802) 241-2345 http://dail.vermont.gov/dail-statutes
Nursing Facility Regulations	DLP: (802) 241-2345 http://dail.vermont.gov/dail-statutes



Table D: Local Contacts

1. Long-Term Care Clinical Coordinators (DAIL/DDAS)

District Office	Phone	Fax
Barre	(802) 476-1646	(802) 476-1654
Bennington	(802) 447-2850	(802) 447-2789
Brattleboro	(802) 251-2118	(802) 254-6394
Burlington	(802) 879-5904	(802) 879-5620
Hartford	(802) 296-5592	(802) 295-4148
Middlebury	(802) 388-5730	(802) 388-4637
Morrisville	(802) 888-0510	(802) 888-0536
Newport	(802) 334-3910	(802) 334-3386
Rutland	(802) 786-5971	(802) 786-5882
Springfield	(802) 885-8875	(802) 885-8879
St. Albans	(802) 524-7913	(802) 527-4078
St. Johnsbury	(802) 748-8361	(802) 751-2644
Waterbury Central Office	(802) 241-1228	(802) 241-4224

2. Local Area Agencies on Aging (Senior Helpline: 1-800-642-5119)

Champlain Valley Agency on Aging	(802) 865-0360
Northeastern VT Area Agency on Aging	(802) 748-5182
Central VT Council on Aging	(802) 479-0531
Southwestern VT Council on Aging: Bennington	(802) 442-5436
Rutland	(802) 786-5991
Southeastern VT Council on Aging	(802) 885-2655

3. Local Home Health Agencies

Addison County Home Health & Hospice	(802) 388-7259
Bennington Area Home Health	(802) 442-5502
Caledonia Home Health	(802) 748-8116
Central VT Home Health	(802) 223-1878
Chittenden / Grand Isle Visiting Nurse Association	(802) 658-1900 (TDD) or (800) 833-6111
Franklin County Home Health Agency	(802) 527-7531
Lamoille Home Health	(802) 888-4651
Manchester Health Services	(802) 362-2126
Orleans / Essex Visiting Nurse Association	(802) 334-5213
Professional Nurses Services	(800) 446-8773
Rutland Area Visiting Nurse Association	(802) 775-0568
Visiting Nurse Alliance of VT & NH	(800) 858-1696

4. DCF/ESD District Offices

Barre	(802) 479-1041 or 800 499-0113
Bennington	(802) 442-8541 or 800 775-0527
Brattleboro	(802) 257-2820 or 800 775-0515
Burlington	(802) 863-7365 or 800 775-0506
Hartford	(802) 295-8855 or 800 775-0507
Middlebury	(802) 388-3146 or 800 244-2035
Newport	(802) 334-6504 or 800 775-0526
Rutland	(802) 786-5800 or 800 775-0516
Springfield	(802) 886-8856 or 800 589-5775
St. Albans	(802) 524-7900 or 800 660-4513
St. Johnsbury	(802) 748-5193 or 800 775-0514
Waterbury Central Office	(802) 241-2800

Vermont 2-1-1: Vermont 2-1-1 is a simple number to dial for information about health and human service organizations in your community. By dialing 2-1-1, information is much easier to find. Callers will speak with a real person every time. Call Specialists will problem solve and refer callers from throughout Vermont to government programs, community-based organizations, support groups, and other local resources.

More information can be found online at: <http://www.vermont211.org/>.

APPENDIX D
DRAFT INFORMED CONSENT FORM

APPENDIX D
Choices for Care

Consent to Participate in Vermont Money Follows the Person Program

I, _____, freely choose to participate in the Vermont Money Follows the Person (MFP) program. I understand that this program allows me to receive a limited amount of flexible funds for expenses related to my transition from the nursing facility where I currently live to a new home in the community.

I have received information about the MFP program and am aware of all aspects of the transition process. I have also received information about the services and supports that will be provided to me both during the MFP demonstration and thereafter, which are all part of the Choices For Care Program.

I understand that participation in MFP is voluntary and that I can withdraw from participation in the MFP project at any time. I understand that I will participate in developing a plan of care that outlines my services, a backup plan and my emergency contact list.

I understand that agreeing to participate in the MFP program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my MFP program eligibility. I understand that there are no additional risks anticipated based on my participation in the MFP program beyond the risks related to receiving services in a community setting, for which I have already provided my consent. I have also been provided with a copy of the Choices For Care Participant Handbook that outlines my rights and responsibilities.

In order to participate in the MFP program, I have been informed that I must meet all of the eligibility requirements specific to the MFP program, which include residing in an inpatient facility for at least ninety (90) consecutive days; receiving Medicaid benefits for inpatient services; and that I must choose to live in a qualified residence, defined as:

1. A home owned or leased by myself or a family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 4 other unrelated individuals reside.

As an MFP participant, I will be asked to complete three short surveys about my quality of life. I will still be eligible to receive flexible funds for transition even if I do not complete the surveys. I understand that any information collected about me will be kept confidential and only be used for evaluating the project.

If I am re-institutionalized for more than thirty (30) consecutive days, I will be reevaluated for continued MFP eligibility and have an updated plan of care developed. If after three incidences/occurrences of re-institutionalization of thirty (30) consecutive days or longer I may no longer be considered for reentry into the MFP Project.

My signature below indicates that I agree to participate in the MFP program if I am determined eligible and that any questions that I may have about the program have been answered.

APPENDIX D

<u>MFP Participant Acknowledgement</u>
Participant Name
Participant Signature
Date Signed:
<u>Guardian/Legal Representative Acknowledgement (if applicable)</u>
Guardian/Legal Representative Name
Guardian/Legal Representative Signature
Date Signed:
<u>Transition Coordinator Acknowledgement</u>
Transition Coordinator Name
Transition Coordinator Signature
Date Signed:

APPENDIX E
LETTERS OF ENDORSEMENT

APPENDIX E

December 29, 2010

Susan Besio, Ph.D., Commissioner

Department of Vermont Health Access (DVHA)

312 Hurricane Lane, Suite 201

Williston, Vermont 05495

Dear Commissioner Besio:

I am a private citizen and consumer enrolled in the Vermont Choices for Care waiver—a waiver that enables me to live in the community. Because I live in the community, I am able to have a tortoise and to attend school and to work. I can also personalize my apartment with decorations, and set in up in the most accessible way possible. These freedoms that I experience should be available to all. To this end, I am writing to endorse the state's application for funding under the Money Follows the Person Grant Program.

All Vermonters receiving long term care should have the option of remaining in, or returning to the community, if it safe to do so. The Money Follows the Person program will make this choice available to nursing facility residents who today lack housing alternatives and face other challenges that keep them in a nursing facility. As my example shows, community living greatly enriches my life. Vermont has long been a leader in deinstitutionalization for individuals with disabilities. Granting the state this Money Follows the Person application allows the state to uphold its tradition of inclusion and to continue serving as a model for other states. I know that funders prefer results that are easily quantifiable, with high numbers. The fact of the matter is, though, I cannot quantify my enjoyment at living in an environment among my peers. Although the fiscal costs of Money Follows the Person may be high, the positive results for former facility residents are incalculable. If this country truly is going to practice what it preaches in terms of liberty and justice for all, then facility residents must have the liberty to live in the community if they choose to do so. Many studies have proved it is cheaper to keep someone in the community than to house them in a facility.

Thank you for creating the Money Follows the Person program. I hope you will approve Vermont's request and provide the funding necessary to help residents of nursing facilities in our state who wish to return to their communities.

Sincerely,
Jill M. Allen



412 Farrell Street, Suite 300
South Burlington, VT 05403
(802) 863-5625

E-mail: home@sover.net
Website: HomeShareVermont.org
Fax: (802) 651-0881

Board of Directors

David Porteous
President

Dan Stanyon
Vice-President

John Draper
Treasurer

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Secretary

Kate Baldwin
Ruth Barenbaum

Estelle Deane
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Zachary Manchester

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Joyce Reddy-Bradbee

Chris Walker

Staff

Kirby Dunn
Executive Director

Ali Fogel
Outreach Coordinator

Amy Jelen
Homesharing Coordinator

MaryLou Thorpe
Caregiving Coordinator

Dorothy Howe
Office Assistant

Holly Reed
Office Manager

Alexis Seubert
AmeriCorps Member

December 27, 2010

Susan Besio, Commissioner
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

RE: Letter of Support

Dear Commissioner Besio:

I am writing on behalf of HomeShare Vermont in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

HomeShare Vermont works with elders and persons with disabilities to help them stay in their homes and we match them with people looking for an affordable place to live who can offer some service in exchange for reduced rent. We have over twenty-five years of experience in recruiting, screening and matching people interested in homesharing. We work closely with the Vermont Department of Disabilities, Aging and Independent Living.

Through the Choices for Care Waiver, Vermont has been a leader in providing alternatives to nursing facility placement for people who need long term care. Vermont has an excellent infrastructure of programs and services designed to help people stay at home or return home. The Money Follows the Person Demonstration offers another option for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this grant application.

Sincerely,

Kirby Dunn
Executive Director





State of Vermont
Department of Mental Health
Office of the Commissioner
103 South Main Street
Wasson Hall
Waterbury, VT 05671-2510
www.mentalhealth.vermont.gov

Agency of Human Services

[phone] 802-241-4008
[fax] 802-241-4009
[tty] 800-253-0191

December 27, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

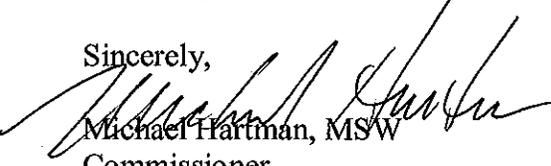
Dear Commissioner Besio:

I am writing on behalf of the Department of Mental Health in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

The receipt of these funds would allow for an expansion of the work that our state has done to move persons with long term care needs out of institutional care. DMH would see this grant as helpful to nurture the mental health provider system in supporting these persons who do have physical care need, but also have mental wellness support needs. As the primary contractor for community based mental health services DMH would work to create access points for persons who might receive services via this application. This would also serve to further increase the DMH and Department of Disabilities, Aging, and Independent Living (DAIL) collaborations to improve mental health services for elders and others with long term needs.

Vermont has been a leader, through the Choices for Care waiver, in providing alternatives to nursing facility placement for new entrants into the long term care program. DMH believes the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this effort.

Sincerely,


Michael Hartman, MSW
Commissioner



Citizens with disabilities working together for dignity, independence, and civil rights

December 30, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Commissioner Besio:

On behalf of the Vermont Center for Independent Living I am writing in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

As you know the Vermont Center for Independent Living is a statewide nonprofit organization of people with disabilities working together for dignity, independence and civil rights. For over thirty-one years, VCIL has been working to promote the full inclusion of Vermonters with disabilities into community life and have fought against people living in institutions when there is a preference for living in the community.

Vermont has been a leader, through the Choices for Care waiver, in providing alternatives to nursing facility placement for new entrants into the long term care program. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this program, and look forward to working with the state on efforts related to the demonstration.

Yours truly,

A handwritten signature in blue ink that reads "Sarah Launderville".

Sarah Wendell Launderville
Executive Director

11 East State Street, Montpelier, VT 05602
802 229-0501, 800 639-1522 (voice & TTY), fax: 802 229-0503
email: vcil@vcil.org web site: www.vcil.org



With offices in Bennington, Chittenden, Orleans, Rutland, and Windham Counties



December 28, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Commissioner Besio:

I am writing on behalf of Community of Vermont Elders (COVE) in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Demonstration Program.

COVE's mission is to promote and protect a higher quality of life for Vermont seniors through education and advocacy. Though COVE is not a direct service provider we strongly support programs that allow optimal choice for consumers.

Through the Choices for Care waiver Vermont has been a leader in providing alternatives to nursing facility placement for new entrants into the long term care program. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this effort.

Sincerely,

A handwritten signature in black ink that reads "Thomas C. Davis". The signature is written in a cursive style.

Thomas C. Davis
COVE President

December 27, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Commissioner Besio:

I am writing on behalf of the DAIL Advisory Board in support of Vermont's application for funding under the Money Follows the Person Demonstration Rebalancing Grant Program.

The DAIL Advisory Board was created for the purpose of advising the commissioner with respect to programs and issues affecting older persons and persons with disabilities. We meet monthly throughout the year to learn about DAIL programs, pose thoughtful questions and provide advice and additional input to staff and the leadership. We have closely followed Vermont's approach to increasing the number and quality of home and community based services through the Choices for Care program.

We know that Vermont has been a national leader, through the Choices for Care waiver, in providing alternatives to nursing home placement for new entrants into the long term care system. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to existing residents of nursing facilities who have improved conditions and/or opportunities for support and who wish to return to the community. We strongly endorse this effort.

Sincerely,



Susan Gordon
DAIL Advisory Board Chairperson

Vermont Association of Area Agencies on Aging

Helping Vermonters Age with Independence and Dignity

December 20, 2010

Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Commissioner Besio:

Thank you for the opportunity to offer our collective support for the Department's application for funding under the Money Follows the Person Rebalancing Grant Demonstration Program. As you know, the Area Agencies on Aging have promoted consumer choice and independent living for seniors and adults with disabilities for over three decades. We welcome the opportunity to partner with the state and other community providers to further these goals.

We are deeply committed to providing personal choice to those who are frail and disabled. The staff of our member organizations provides support in a variety of forms to over 10,000 consumers and family caregiver each year, all with the goal of helping these individuals maximize their personal independence in a manner consistent with their values and preferences. We believe that Vermont's participation in the Money Follows the Person Demonstration can further advance our work in this regard, and enthusiastically offer our support for this initiative.

As you know, Vermont has been a leader, through the Choices for Care waiver, in providing alternatives to nursing facility placement for new entrants into the long term care program. We believe the Money Follows the Person Demonstration offers an important opportunity for Vermont to expand the choices available to nursing facility residents who wish to return to the community. We strongly endorse this effort, and stand ready to assist with both material and in-kind support. Please let me know if we can be of additional assistance.

Sincerely,



Ken Gordon, President
Vermont Association of Area Agencies on Aging

Appendix E-7



*Champlain Valley
Agency on Aging, Inc.*
802-865-0360
www.cvaa.org



*Northeastern Vermont
Area Agency on Aging, Inc.*
802-748-5152
www.nevaaa.org



*Central Vermont
Council on Aging, Inc.*
802-479-0531
www.cvcoa.org



*Southwestern Vermont
Council on Aging, Inc.*
802-786-5991
www.svcoa.org



*Council on Aging
for Southeastern Vermont, Inc.*
802-885-2655
www.coasevt.org

APPENDIX F
CHOICES FOR CARE EMERGENCY CONTACTS AND BACK-UP PLAN

Choices for Care-Department of Disabilities, Aging and Independent Living

Emergency Contacts & Back-up Plan

This plan shall be reviewed and updated by the case manager as needed. A copy must be maintained in the individual's home in a conspicuous place.

Date created: _____

I. Emergency Contacts

In the event of a medical emergency or fire, call 911.

Emergency family/friend contact: _____

Relationship to individual: _____

Phone numbers: _____/home _____/work

Primary Doctor: _____

Normal hours of operation: _____ phone number: _____

After-hours on-call phone number: _____

Home Health Agency: _____

Normal hours of operation: _____ phone number: _____

After-hours on-call phone number: _____

Case Management Agency: _____

Normal hours of operation: _____ phone number: _____

After-hours on-call phone number: _____

NOTE: Individuals enrolled with a **Personal Emergency Response System (PERS)** provider may push the PERS button in any emergency. For questions regarding PERS services, contact your case manager.

II. Back-up Personal Care

In the event that the personal care attendant is unavailable, indicate at least one confirmed back-up person to contact that can fill-in to provide or arrange for care:

1. Name: _____

Relationship to individual: _____

Phone numbers: _____/home _____/work

2. Name: _____

Relationship to individual: _____

Phone numbers: _____/home _____/work

If none, indicate reason:

APPENDIX G
SUB APPENDIX 1 – SELF-DIRECTION SUBMITTAL FORM

Sub-Appendix I: Self-Direction

Components of Self-Direction from the 1915(c), 3.5 Waiver Application

Participant direction of waiver services means that the participant has the authority to exercise decision making authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered service plan. Participant direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. For example, the participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports. When a service is provider-managed, a provider selected by the participant carries out these responsibilities.

Incorporating participant direction involves several interrelated dimensions. The following is an overview of the main dimensions of participant direction:

Participant Choice

Self-direction may permit participants to direct some or all of their services or opt instead to receive provider-managed services exclusively. Decision making authority, references to the participant mean: (a) the participant acting independently on her/his own; (b) the parent(s) of a minor child who is a waiver participant acting on behalf of the child; (c) a legal representative when the representative has the authority to make pertinent decisions on behalf of the participant; and, (d) when permitted by the state, a non-legal representative who has been freely chosen by the participant to make decisions on the participant's behalf.

Participant Direction Opportunities

There are two basic participant direction opportunities. These opportunities may be and often are used in combination and are not mutually exclusive. The opportunities are:

- **Participant Employer Authority.** Under the Employer Authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the common law employer or the co-employer of these workers. When the Employer Authority is utilized, the participant rather than a provider agency carries out employer responsibilities for workers.
- **Participant Budget Authority.** Under the Budget Authority, the participant has the authority and accepts the responsibility to manage a participant-directed budget. Depending on the dimensions of the budget authority it permits the participant to make decisions about the acquisition of goods and services that are authorized in the service plan and to manage the dollars included in a participant-directed budget.

Supports for Participant Direction

Two types of supports may be made *available* to facilitate participant direction. These supports may be furnished as a service under a Medicaid payment authority (principally as a Medicaid administrative activity).

- **Information and Assistance in Support of Participant Direction:** These supports are made available to participants to help them manage their waiver services. For example, assistance might be provided to help the participant locate workers who furnish direct supports or in crafting the service plan. The type and extent of the supports that must be available to participants depends on the nature of the participant direction opportunities provided.
- **Financial Management Services:** These services are furnished for two purposes: (a) to address Federal, state and local employment tax, labor and workers' compensation insurance rules and other requirements that apply when the participant functions as the employer of workers and (b) to make financial transactions on behalf of the participant when the participant has budget authority. There are two types of FMS services that may be employed to support participants who exercise the Employer Authority: (1) Fiscal/Employer Agent (Government or Vendor) where the entity is the agent to the common law employer who is either the participant or his or her representative or (2) Agency with Choice, where the participant and the agency function as co-employers of the participant's worker(s). While their main purpose is to facilitate participant direction of services, these supports also provide important protections and safeguards for participants who direct their own waiver services.

CMS Funding Sources

Self-Direction can be funded by a variety of mechanisms by CMS, including funding authorities such as section 1915(c) home and community-based services waiver programs and section 1915(b) managed care, waiver programs. The Deficit Reduction Act of 2005 added new options for self-directed services States that wish to continue self-direction beyond the grant period for individuals will need to consider which authority to use. These options are summarized in the table below. (Note: section 1915(c) waiver authority policy on self-direction was developed in conjunction with the 1915(c) waiver application and is comprehensively documented in the Instructions, Technical Guide and Review Criteria for the application found at the following website: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers

Reading the provisions in the 1915(c) waiver template are a good starting point for all self-direction initiatives. Various restrictions are present under this and other authorities and CMS should be consulted if you have questions about the authority that is best suited to your circumstances. The following table summarizes significant issues under the various authorities.

	Component		Funding Authority		
	1915(c)	1915(b)	Benchmarks (DRA 6044)	Section 1915(i) (DRA 6086)	Section 1915(j) (DRA 6087)
Services	See Appendix C of the waiver instructions for service options	Includes ability to use savings from managed care programs to fund alternative services	Includes ability to create enhanced service packages	Includes HCBS allowed under 1915(c)	Can self-direct either State plan PCS or HCBS under 1915(c)
State -wideness	May waive	May waive	May waive	Cannot-	States may disregard
Comparability	States may waive	States may waive	States may waive	Cannot	States may disregard
Populations	Populations who meet a Medicaid institutional level of care	Includes all populations	Includes all populations	Includes all populations	Includes all populations
Authority to Manage Cash	Cannot manage cash	Cannot manage cash	May not manage cash	May not manage cash	Allowed, at State's option
Limit #s of people	May limit numbers	May limit numbers	May limit numbers	May not limit numbers	May limit numbers
Institutional Eligibility Rules	May waive	May waive	May waive	May waive	Does not change person's eligibility for either State plan PCS or HCBS waiver services
[1902(a)(10)(c)(i)(III)] Provider Agreements [1902(a)(27)]	May not waive	May not waive	May not waive	May not waive	May not waive

Self-Direction Submittal Form

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development.** Specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
X	Case Manager. <i>Specify qualifications:</i> All case managers must complete the required state case management training and also receive appropriate supervision. All case managers must be certified. Certification remains in effect unless revoked by DAIL.
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
X	Other (<i>specify the individuals and their qualifications</i>): Transition Coordinators: Hired by DAIL: Qualifications – Minimum of a Bachelor’s Degree in either Health or Human Services.

b. **Service Plan Development Safeguards.** *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other services to the participant.
X	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i> Both Agencies on Aging and Home Health Agencies may provide case management services. Home Health Agencies also may provide personal care, respite and companion services. Consumers have a choice of case management agencies.

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Transition coordinators and/or case managers assist the participant (and/or family or legal representative) to direct and be actively engaged in developing and implementing a service/care plan that addresses the individual's needs, preferences, risk factors, and backup plan. At the discretion of the participant, transition coordinators and/or case managers assist the participant to identify family and/or representative/surrogate supports, caregivers, and others to assist and participate in the service/care planning process and to attend the service/care planning meeting. The participant is also encouraged to be actively involved.

- d. Service Plan Development Process** In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

There are currently three options for self-direction under Vermont's 1115 LTC waiver, Choices For Care, that will be available to MFP participants: self-direction, surrogate-direction and Flexible Choices Program. All three of the options begin with an assessment and the development of the service/care plan to assess an individual's interest in self-directing. The transition coordinator and/or case manager will contact the individual and make arrangements for the completion of the transition assessment, also known as the "Independent Living Assessment (ILA)". This assessment is a comprehensive assessment that involves a complete health and functional needs assessment as well as a risk assessment. The ILA also measures cognitive status. The ILA also assesses mental health status and will provide the transition coordinator and/or case manager with the information needed to develop a care plan to address all of these needs.

To self-direct, the individual must have the cognitive ability to communicate effectively. A registered nurse will complete the ILA and the individual is encouraged to include informal supports in the process. These include family, representatives, surrogates, caregivers, etc. The transition coordinator and/or case manager will assess the individual's circumstances, resources, program eligibility, and formal and informal support systems, as well as the individual's preferences and goals for self-directing services. The results of the assessment will serve as the basis for the development of the individual's plan of care.

The transition coordinator and/or case manager will conduct a review of service options and

discuss any limitations with the individual or their representative/surrogate. The transition coordinator and/or case manager will, in conjunction with the individual and/or their representative/surrogate develop a comprehensive service/care plan that addresses his/her needs. The participant will review the service/care plan and sign-off on the service plan. The completed assessment and signed service plan will be sent to DAIL for staff level review. A copy of the service plan once approved will be given to the participant. Once approved, the individual becomes the employer in consumer/surrogate self-direction. The transition coordinators and/or case managers are trained in the nuances of consumer and surrogate-directed services and are competent in assisting participants in operationalizing this option.

A consumer and surrogate-directed service handbook is given to the individual that offers detailed guidance on the roles and responsibilities of an employer. With the Flexible Choice option the assessment process is the same, only with the consultant in the role of the case manager. Working with the consultant, the individual then develops a budget which details expenditures of the allowance and guides the individual's acquisition of services to meet their needs.

MFP demonstration services will enhance the range of services available to the participant but will not duplicate or supplant. Qualified HCBS including SD/CD and Flexible Option currently covered under the existing CFC program will be offered to MFP participants both during and after the 365-day MFP waiver period. The case manager will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals. They will also ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained.

The participant will be reassessed annually and/or if there is any change in health/condition or needs status. The case manager or consultant will be in contact with the participant at least quarterly while in self-direction. MFP quality management specialists will assure that quality controls are maintained. DAIL tracks the contents of all care/service plans and compares the actual utilization of services by the participant to those services included in the care plan. Other standard monitoring practices include reviews of case management records; interviews with program participants, surrogates and other related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, and resolution and data analysis.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Transition coordinators will complete transition assessments on all MFP participants prior to them leaving a nursing facility. The transition assessment will identify potential risks in transitioning to the community, including situational, environmental, behavioral, medical and financial. The transition coordinator, in collaboration with the participant and the participant's assigned case manager, will develop a care plan. The care plan will identify and document strategies to address the risks identified in the transition assessment as well as an emergency backup plan. Upon completion of the care plan, a copy will be provided to the participant. Care plans will be implemented and monitored by the participant's assigned case manager. The assessment and plan of care are updated at least annually and more often if warranted by changes in the participant's situation or condition.

At the time the care plan is developed, the case manager will assist the individual in developing an emergency backup plan. This plan will indicate at least one individual or agency to contact in the event that a personal care or other service worker does not show up for work. This could consist of both formal and informal providers, such as family, friends and neighbors who have agreed to support the participant on an emergency basis. It will also include a list of emergency contacts.

DAIL clinical staff (LTCCCs) will conduct a thorough utilization review prior to authorizing any modifications to the annual service plan. The LTCCCs will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals. They will also ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained. They will also monitor, directly or indirectly, the delivery of services under the care plans and track the proportion of services included in the plan that are actually delivered to the enrollee.

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

When an individual chooses self-direction, either CD/SD or Flexible Option, they are given a list of qualified services providers and qualified providers. The list will be provided by the transition coordinator and/or case manager after the completion of the initial assessment, care plan and service plan. This will enable the individual to identify what qualified providers are available for the services they can self-direct to begin their selection process.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

The completed assessment and signed service plan will be sent to DAIL for staff level review

and approval. DAIL clinical staff (LTCCCs) conduct a thorough utilization review of each service/care plan. A copy of the service/care plan, once approved, is given to the individual.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
X	Department of Disability, Aging and Independent Living (DAIL
X	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

II. Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The MFP demonstration program will be targeting the Elderly and Physically Disabled population. Transition Coordinators and/or case managers will be responsible for the monitoring and implementation of the service plan and participant health and welfare. The monitoring and follow-up methods will be an annual reassessment by the case manager, at the request of the individual, and/or if there is any change in health/condition or needs status. The case manager will have monthly contact or more frequent if needed with the individual. The annual reassessment will be face-to-face by the case manager. Other standard monitoring practices performed by the case manager and/or QM specialists include reviews of case management records; interviews with program participants, surrogates and other related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, resolution and data analysis. Complaints of abuse, neglect and exploitation are investigated by DAIL and then referred to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Fraud Unit.

- b. **Monitoring Safeguards.** *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>
	Both Agencies on Aging and Home Health Agencies may provide case management services. Home Health Agencies may also provide personal care, respite and companion services. Consumers have choice of case management agencies and may change case management agencies at any time.

III. Overview of Self-Direction

- a. **Description of Self-Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

A: Opportunities afforded to participants: Individuals who are interested in self-directing their supports are made aware that as part of the MFP demonstration under the 1115 long term care waiver there are three choices to self-direct. Both the Consumer-directed (CD) care and the Surrogate-directed (SD) care options allow consumers to hire and manage workers to provide the consumer with personal care, respite or companion services. Under the CD option, the consumer is the employer and under the SD option, a surrogate appointed by the consumer is the employer. The third option, Flexible Choices, provides the consumer or an appointed surrogate with a limited monetary allocation, known as an "allowance" that may be used to hire workers or purchase other goods or services necessary for the consumer's ongoing support needs. **B:** All three of the options begin with the development of the service/care plan. The transition coordinator and/or case manager will contact the individual participant and make arrangements for the completion of the transition assessment called the Independent Living Assessment (ILA). This is done initially, annually and as needed. Transition Coordinators and/or case managers inform participants of the option to self-direct at these times. At any time the participant can chose to self-direct or terminate the self-direction option by notifying the transition coordinator and/or case manager. The transition coordinator and/or case manager will work with the participant to make sure that there is a seamless transition to another option offered through the 1115 long term care waiver, CFC.

C. In Flexible Choices, a contracted consultant will be assigned to help the participant manage their budget and perform tasks that include by not limited to: assuring that the participant has in place an emergency back-up plan; monitoring the services included in an individual's budget; assessing the adequacy of care being provided; certifying the ability of a consumer or surrogate employer to manage services; reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services; and reporting suspected cases of Medicaid Fraud to the State Medicaid Fraud Unit.

Under Flexible Choices, all expenses incurred by participants are billed through the Fiscal Intermediary Services Organization (ISO). The ISO assist the participant and/or representative to manage and distribute funds contained in their budget to include but not limited to: payroll including federal, state and local tax withholdings/payments; unemployment compensation fees, making payments for goods and services; fiscal accounting and expenditure reports. The ISO is required to be utilized by the participant and/or representative that chose to use Flexible Choices.

For those who are enrolled in the consumer or surrogate directed options, an assigned case manager is responsible for:

- Answering questions about the CFC program;
- Assisting individuals in gaining access to needed services;

- Overseeing the assessment and reassessment of the individual;
 - Developing a service plan for the individual;
 - Monitoring the services included in an individual's service plan;
 - Assessing the adequacy of care being provided;
 - Certifying the ability of a consumer or surrogate employer to manage services;
 - Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services; and
 - Reporting suspected cases of Medicaid Fraud to the State (see Chapter VIII).
- D. No other relevant information

b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the demonstration. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in Appendix E-2, Item a , the participant (or the participant’s representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in Appendix E-2, Item b , the participant (or the participant’s representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	Both Authorities. The demonstration provides for both participant direction opportunities as specified in the 1115 long term waiver Appendix E-2 . Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
<input checked="" type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
<input checked="" type="checkbox"/>	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual’s family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (select one):

X	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time the participant expresses an interest in self-direction, the transition coordinator and/or case manager will provide him/her with the CFC Employer Handbook, Flexible Choices brochures and other informational materials on SD/CD and Flexible Choices. The participant will also be given the **“Help at Home: A Guide to Finding and Keeping Your Caregiver”** (published by Homeshare Vermont, Burlington, VT), for helpful information and tips on hiring, training and keeping caregivers/workers. **EMPLOYERS** may obtain a guide by contacting the Choices for Care case manager or Homeshare Vermont or <http://www.homesharevermont.org/>. This information can be given at the initial assessment, at any reassessment or when the participant request or expresses an interest in self-direction.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of demonstration services by a representative (select one):

○	The State does not provide for the direction of demonstration services by a representative.	
X	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: <i>(check each that applies):</i>	
	X	Demonstration services may be directed by a legal representative of the participant.
	X	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities), available for each demonstration service. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Personal Care	X	X
Respite Care	X	X
Companion Care	X	X
Adult Day	<input type="checkbox"/>	X
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one:*

X	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
X	Governmental entities
<input type="checkbox"/>	Private entities
O	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one:*

O	FMS are covered as a Demonstration service	Fill out i. through iv. below:
X	FMS are provided as an administrative activity. Fill out i. through iv. below:	
	i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: Participants enrolled in consumer or surrogate directed care as well as Flexible Choices must use the Fiscal Intermediary Services Organization (ISO). Fiscal ISO is paid by Vermont Medicaid for actual costs. The ISO will be used for the MFP demonstration if the participant chooses consumer or surrogate directed care as well as Flexible Choices.
	ii.	Payment for FMS. Specify how FMS entities are compensated for the activities that they perform: In all of DAIL's self-directed programs, all expenses incurred by participants are billed through the Fiscal Intermediary Services Organization (ISO). The

	ISO assists the participant and/or representative to manage and distribute funds contained in their budget to include but not limited to: payroll including federal, state and local tax withholdings/payments; unemployment compensation fees, making payments for goods and services; fiscal accounting and expenditure reports. The ISO is required to be utilized by the participant and/or representative that chose to use consumer or surrogate directed services as well as Flexible Choices.
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>):
	<i>Supports furnished when the participant is the employer of direct support workers:</i>
	<input checked="" type="checkbox"/> Assist participant in verifying support worker citizenship status
	<input checked="" type="checkbox"/> Collect and process timesheets of support workers
	<input checked="" type="checkbox"/> Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	<input type="checkbox"/> Other (<i>specify</i>):
	<i>Supports furnished when the participant exercises budget authority:</i>
	<input checked="" type="checkbox"/> Maintain a separate account for each participant's self-directed budget
	<input checked="" type="checkbox"/> Track and report participant funds, disbursements and the balance-of participant funds
	<input checked="" type="checkbox"/> Process and pay invoices for goods and services approved in the service plan
	<input checked="" type="checkbox"/> Provide participant with periodic reports of expenditures and the status of the self-directed budget
	<input type="checkbox"/> Other services and supports (<i>specify</i>):
	<i>Additional functions/activities:</i>
<input checked="" type="checkbox"/> Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	
<input checked="" type="checkbox"/> Other (<i>specify</i>):	
Run background checks on all workers as required by DAIL and disqualify workers who fail to meet the background check standards	
iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
	The ISO serves as an agent of the State and is responsible for submitting the State of Vermont monthly report of the funds and expenditures under their control. The State meets monthly with the ISO to review their activities. The ISO also is sends monthly statements of expenditures to individual

participants. DAIL is responsible for monitoring the ISO.

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

X	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:</i></p> <p>Case Managers assist participants enrolled in Surrogate and Consumer Directed services and Consultants assist participants in Flexible Choices. Both Case Managers and Consultants certify an individual or surrogate as an “employer”, train the participant, develop the service plan or budget and support the participant to be involved in the planning process. The case managers and consultants supply the participants will a list of qualified providers and services that can be self directed. They also monitor the services and make changes to the service plan as needed. Case Managers and Consultants also:</p> <ul style="list-style-type: none"> • assure that the participant has in place an emergency back-up plan; • assess the adequacy of care being provided; • reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services; and • reporting suspected cases of Medicaid Fraud to the State Medicaid Fraud Unit. 	
x	<p>Demonstration Service Coverage. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled:</p> <table border="1" data-bbox="792 1325 1438 1367"> <tr> <td>Case management</td> </tr> </table>	Case management
Case management		
□	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p>	

- k. Independent Advocacy** (*select one*).

x	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p>
---	--

	Independent advocacy is available through the AAAs, ARDCs, CILs/SCILs, Office of the Ombudsman, Flexible Choices consultants to participants. They can access any of these agencies by contacting the local office.
○	No. Arrangements have not been made for independent advocacy.

I. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants in either program may voluntarily terminate self-direction in order to receive services through an alternate service delivery method, such as a traditional provider. To accommodate this, the case manager or consultant will educate the enrollee on giving adequate notice to their worker so that alternative arrangements can be made. This may take up to two weeks if necessary and will provide the consultant or case manager the necessary time to follow standard procedures to switch the service(s) from self-direction to an alternative service delivery method.

When voluntary switches occur, the participant and/or guardian contacts the consultant or case manager, who coordinates services with a waiver- enrolled provider agency, selected by the participant, and then updates the service plan to reflect the services that have been modified. A copy of the revised service plan is then given to the participant. The consultant or case manager, through contact with service providers and follow-up calls to the participant, assures that services are in place. He/she continues to monitor the health and welfare of the participant during the transition through phone calls, in-person visits, running late or missed visit reports, and re-assessing the participant as necessary.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The participant may be involuntarily switched from SD, CD or Flexible Choices options to provider-managed services for any of (but not limited to) the following reasons: 1) participant is not able to manage the requirements of being an “employer” or the requirements of the Flexible Choices Program; 2) the participant or surrogate commits fraud or otherwise inappropriately uses their resources; or 3) the participant’s health, safety or welfare is at risk for any reason. (Participants who 1) become no longer eligible for Choices for Care or 2) die will be involuntarily removed from one of the self-directed options but will not be transferred to another Choices for Care option.) The consultant or case manager plans and implements the return of the participant to provider-managed services as well as reports any health, safety, fraud, or abuse concerns to the appropriate state agencies. The final determination in all cases of involuntary disenrollment is made by the case management or consultant agency.

Participants who are involuntarily disenrolled from SD, CD or Flexible Choices, but are still

eligible for CFC, will have a new care plan developed for an expeditious and safe transfer to another CFC option. It will be developed for them by the consultant or case manager working with them. As is the case with voluntary termination, the consultant or case manager, through contact with service providers and follow-up calls to the participant, assures that services are in place. He/she continues to monitor the health and welfare of the participant during the transition through phone calls, in-person visits, running late or missed visit reports, and re-assessing the participant as necessary. Any suspected cases of abuse, neglect, exploitation are reported to Adult Protective Services.

n. **Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	Number of Participants	Number of Participants
Year 1	5	3
Year 2	6	3
Year 3	7	3
Year 4	8	4
Year 5	9	4

Participant Employer

a. **Participant – Employer Authority** (Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

1. **Participant Employer Status.** Specify the participant's employer status under the demonstration. Check each that applies:

<input type="checkbox"/>	<p>Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:</i></p>
<input checked="" type="checkbox"/>	<p>Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.</p>

2. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

X	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The costs of background checks are considered part of the administrative costs for an agency or provider, and are part of the contract for services of an ISO.
X	Specify additional staff qualifications based on participant needs and preferences
X	Determine staff duties consistent with the service specifications
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)

<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

b. Participant – Budget Authority (Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)

1. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

X	Reallocate funds among services included in the budget
X	Determine the amount paid for services within the State's established limits
X	Substitute service providers
X	Schedule the provision of services
X	Specify additional service provider qualifications
X	Specify how services are provided,
X	Identify service providers and refer for provider enrollment
X	Authorize payment for demonstration goods and services
X	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (specify):

2. **Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Participant Goals and Budget Development: The budgeting process is person centered and begins with the participants' identifying goals for their maintaining or enhancing their health, well-being and independence at home that they want to meet using their allowance. These goals guide not only the budget development process but also the monitoring and evaluation process. Budgets are agreed upon by the consultant and the participant after an assessment of personal care, respite care, adult day and companion care needs is performed.

Either the participant or the consultant may consult with DAIL staff if they have questions or if they feel that they need assistance from a third party to resolve difficult issues. The allowance is the number of dollars the individual has available to them to pay for their care. The allowance is calculated on the basis of a two-week allocation.

The allowance amount is derived from the individual's current Service Plan. If the participant's needs have changed since his or her most recent assessment, the consultant will complete a

new assessment and the allowance will be based on that assessment.

Specific allowance amounts will be derived from three components: a base amount which will be the same for all participants, a personal care amount and an adult day amount. Allowance amounts are approved by the Long Term Care Clinical Coordinator.

3. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Budgets are agreed upon by the consultant and the participant. Either the participant or the consultant may consult with DAIL staff if they have questions or if they feel that they need assistance from a third party to resolve difficult issues. Requests for additional adjustments in the budget amount are directed by the consultant to the LTCCC.

4. **Participant Exercise of Budget Flexibility. Select one:**

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input checked="" type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

5. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Participants receive a financial statement from the Fiscal ISO after each payroll. This includes a beginning and ending balance and an itemized listing of all expenditures during that pay period. It also includes current accrued savings. A copy of this report also goes to the consultant. The ISO monitors expenditures and notifies the participant and consultant when spending exceeds budgeted amounts. All charges, except consultant and Fiscal ISO fees, require the participant's signature. The Fiscal ISO informs the participant via telephone whenever they have to pull money from other budget items to cover payroll. They inform the consultant if there appears to be a pattern with the participant's being unable to manage his/her care within the budgeted amount. The consultant also reviews the bi-weekly financial statement to assure that the participant's plan is being properly implemented. Consultants must contact participants weekly for the first month and monthly throughout their period of participation in Flexible Choices.

That monthly contact will include:

- a) Review and update, if appropriate, of the participant's goals ;
- b) Review of the budget including budget expenditures;
- c) Ascertaining the participant's perception of their wellbeing; and
- d) Discussion of any problems or concerns perceived by the consultant

APPENDIX H
DRAFT INCIDENT REPORT FORM

APPENDIX H

DIVISION OF DISABILITY AND AGING SERVICES
DEPARTMENT OF DISABILITIES, AGING & INDEPENDENT LIVING CRITICAL INCIDENT REPORT

DAIL
103 South Main Street
Waterbury, VT 05671-1601
Phone: Fax:

Please print	
Name of Person: _____	Date of birth ____/____/____
Agency: _____	
Guardian: _____	__ Public __ Private
Individual Reporting: _____	Title: _____

Date of Critical Incident: ____/____/____ Time: _____

Type of Incident – Check all that Apply:

- Death (Call 1-802-353-8276, if no answer 1-800-642-3100 immediately)
- Missing person (Call 1-802-353-8276, if no answer 1-800-642-3100 immediately)
- Suspected abuse, neglect, exploitation: __ of person __ by person
- *Call 1-800-564-1612 Adult Protective Services, to report abuse of an adult*
- Serious injury/medical condition requiring treatment by a physician
- Medication error requiring treatment by a physician
- Criminal act by a person who receives services
- Criminal act by staff/worker
- Use of a restraint
- Unexpected hospitalization
- Other critical incidents such as fire, theft or destruction of property, criminal act or unusual events (please specify here) _____

Who Was Notified About This Incident?

- Case Manager Guardian MFP Project Director APS MFP Quality Specialist
- Other (please specify) _____

APPENDIX H

Description of Incident:

Review completed by: ___ Case Manager **and** ___ Quality Management Specialist

Case Manager Name: _____ Phone #: _____ Date: _____

Quality Management Specialist Name: _____

Phone#: _____ Date: _____

Action Taken:

Is follow-up needed? ___ Yes ___ No (if yes, please describe the follow-up activities and who is performing them)

Date Report was closed: _____

Date Report was reviewed by DAIL QM Committee: _____

APPENDIX I
PROJECT DIRECTOR JOB DESCRIPTION

Vermont MFP Demonstration Program

1

Position Title: Project Director**Main functions:**

The Project Director will be responsible for leading the design, development, implementation, and plans for sustaining the CMS MFP demonstration.

Reports to: Department of Disability, Aging and Independent Living (DAIL) Commissioner**Duties:**

- Hire personnel for program implementation
- Responsible for overall quality and management of MFP program
- Oversees budget and ensure financial accountability
- Supervise program delivery
- Recognize and solve potential problems and evaluate program effectiveness
- Ensure operating procedures meet program goals
- Provide program content expertise
- Facilitate MFP Steering Committee Meetings
- Facilitate ad-hoc workgroups and forums
- Address capacity issues as they arise
- Perform quality functions
- Network with local, state and national agencies for future program development as required.

To perform this job successfully, an individual must be able to perform each duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required.

- Excellent supervisory, organizational and training skills
- Experience in program development and implementation
- Experience in coordinating activities, evaluating data, and establishing priorities
- Excellent communication and presentation skills
- Ability to analyze problems and make well-reasoned, sound decisions
- Related grant experience

EDUCATION and/or EXPERIENCE:

Master's Degree Required

APPENDIX J
MFP MAINTENANCE OF EFFORT FORMS

Maintenance of Effort (MOE) Form
Money Follows the Person Demonstration Grant Program (Nov 2010)

STATE:	VT	Grant #:	CMS-11I-11-001
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Reporting Year Format: State Fiscal Year X (Fiscal YEAR RUNS: July 1-June 30)
 FEDERAL FISCAL YEAR _____ Calendar Year _____

Total State Expenditures for Home & Community-based Services

Base Year					
	2007	2008	2009	2010	2011
				\$55,491,924	

2012	2013	2014	2015	2016	2017

2018	2019

Attestation (required by Section 6071 of the Deficit Reduction Act of 2005)

I assert by my signature that the expenditure report above is accurate and follows the MFP MOE Form instructions. I also assert that all qualified HCBS programs operating under a waiver under section (d) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

Signature :	<i>Patricia F. Coord</i>	Date:	<i>1/5/11</i>
Title/Position:	<i>DEPUTY SECRETARY, AHS</i>		

Instructions

1. Fill out your State and Official Grant Number.
2. Check off the Report year you will be using. If it is the State Fiscal Year, indicate the dates of the year the report covers. You must report by either State FY, Federal FY or Calendar year.
3. Fill in each year's expenditures for HCBS starting with the base year which you will fill in. The base year is the immediate previous full year of expenditures based on the reporting year format you have chosen. For new applicants for 2011 provide only your base year. For existing grantees only provide the base year and the first full year you began your grant through the latest reporting period.
4. Medicaid HCBS Expenditures include all non-institutional services and include waiver and HCBS State plan services such as personal care services, rehab services and other State plan services you cover that are non-institutional.
5. The State authorized signatory must sign and date as well as identify their Title or position as indicated. The second element to attest to is the continuation of meeting cost neutrality in the waivers your State provides.

APPENDIX K
SUB APPENDIX IV – WORKSHEET FOR PROPOSED BUDGET

APPENDIX K

Money Follows the Person Demonstration Worksheet for Proposed Budget (revised January 2011)

Instructions: Please fill in **only** the cells highlighted in YELLOW. All other cells will autopopulate. **Please DO NOT alter any formulas.**

Please note: The enhance rate for FFY2009 thru FFY2011 is based on the increased FMAP rate related to the implementation of the Recovery Act of 2009 & the Education, Jobs and Medicaid Assistance Act of 2010. Budget calculations for the last quarter of CY2008 thru the first two quarters of CY2011 use these rates.

Date of Report:		Please express FMAP as a decimal. (example: 68.32%=.6832)					
Name of State/Grantee:		State FMAP (Hold Harmless Rate Oct 2008 - Dec 2010)		State Enhanced FMAP	Increased FMAP (Oct 2008 - Jun 2011)	ALLOWED Enhanced FMAP Not to Exceed 90%	Calculated Enhanced FMAP (Oct 2008 - Dec 2010)
Grant #:		FFY 2007		0.50000		0.50000	
Demonstration Program Title:		FFY 2008		0.50000		0.50000	
	10-12/2008	FFY 2009 Q1		0.50000		0.50000	0.50000
	1-3/2009	FFY 2009 Q2		0.50000		0.50000	0.50000
	4-6/2009	FFY 2009 Q3		0.50000		0.50000	0.50000
	7-9/2009	FFY 2009 Q4		0.50000		0.50000	0.50000
	10-12/2009	FFY 2010 Q1		0.50000		0.50000	0.50000
	1-3/2010	FFY 2010 Q2		0.50000		0.50000	0.50000
	4-6/2010	FFY 2010 Q3		0.50000		0.50000	0.50000
	7-9/2010	FFY 2010 Q4		0.50000		0.50000	0.50000
	10-12/2010	FFY 2011 Q1		0.50000		0.50000	0.50000
	1-3/2011	FFY 2011 Q2		0.50000		0.50000	0.50000
	4-6/2011	FFY 2011 Q3		0.4129	0.70645	0.52670	0.52670
	7-12/2011	FFY 2011 Q4		0.4129	0.70645	0.52670	0.52670
		FFY 2012		0.4242	0.71210	0.71210	
		FFY 2013		0.4242	0.71210	0.71210	
		FFY 2014		0.4242	0.71210	0.71210	
		FFY 2015		0.4242	0.71210	0.71210	
		FFY 2016		0.4242	0.71210	0.71210	

APPENDIX K

Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition.
All population counts and budget estimates are based on the *Calendar Year (CY)*.

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total per CY
CY 2007						0
CY 2008						0
CY 2009						0
CY 2010						0
CY 2011	43		7			50
CY 2012	47		8			55
CY 2013	52		8			60
CY 2014	56		9			65
CY 2015	60		10			70
CY 2016	65		10			75
Total Count	323	0	52	0	0	
				Total of Populations	375	

Demonstration Budget Summary

Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services are defined in the RFP.

Administration - Normal - costs that adhere to CFR Title 42, Section 433(b)(7); *Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10); *Administrative - Federal Evaluation Supports* - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).

Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the *Enhanced FMAP Rate* that could be reinvested into rebalancing benchmarks.

Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2016)	Rate	Total Costs	Federal	State
Qualified HCBS		\$ 266,845	\$ 187,594	\$ 79,251
Demonstration HCBS		\$ 937,500	\$ 659,405	\$ 278,095
Supplemental		\$ -	\$ -	\$ -
Administrative - Normal		\$ -	\$ -	\$ -
Administrative - 75%		\$ -	\$ -	\$ -
Administrative - 90%		\$ -	\$ -	\$ -
Federal Evaluation Supports		\$ 37,500	\$ 37,500	\$ -
Administrative (Other) - 100%		\$ 5,317,022	\$ 5,317,022	\$ -
State Evaluation		\$ -	\$ -	\$ -
Total		\$ 6,558,867	\$ 6,201,522	\$ 357,346

Per Capita Service Costs	\$ 3,212
Per Capita Admin Costs	\$ 14,179

Rebalancing Fund Calculation	
CY 2007	\$ -
CY 2008	\$ -
CY 2009	\$ -
CY 2010	\$ -
CY 2011	\$ 37,868
CY 2012	\$ 51,027
CY 2013	\$ 55,458
CY 2014	\$ 59,951
CY 2015	\$ 64,508
CY 2016	\$ 69,135
Rebalancing Fund Total	\$ 337,947

APPENDIX K

CY 2007	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.50000	\$ -	\$ -	\$ -	Grant Funding for CY 2007	\$ -
Demonstration HCBS	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Supplemental	0.00000	\$ -	\$ -	\$ -	Balance (Carry Over)	
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ -
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ -
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

CY 2008 (including Partial Year Increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan - Sept)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Demonstration HCBS (Jan - Sept)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Demonstration HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ -
Supplemental (Jan - Sept)	0.00000	\$ -			Total (Balance + Request)	\$ -
Supplemental (Oct - Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

APPENDIX K

CY 2009 (using Increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Qualified HCBS (Jul- Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ -
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ -
Demonstration HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Jul- Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Jul- Sep increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Oct - Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

APPENDIX K

CY 2010 (using increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total Fed Costs	\$ -
Qualified HCBS (Jul- Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 950,403
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 950,403
Demonstration HCBS (Apr-Jun increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Jul- Sep increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Demonstration HCBS (Oct - Dec increased FMAP)	0.50000	\$ -	\$ -	\$ -		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Jul- Sep increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Oct - Dec increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -		
Administrative (Other) - 100%	1.00000	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ -	\$ -	\$ -		

APPENDIX K

CY 2011 (using partial year increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding	\$ 950,403
Qualified HCBS (Apr-Jun increased FMAP)	0.52670	\$ 12,335	\$ 6,497	\$ 5,838	Total Fed Costs	\$ 950,403
Qualified HCBS (Jul-Dec)	0.70645	\$ 24,706	\$ 17,454	\$ 7,253	Balance (Carry Over)	\$ -
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 1,060,819
Demonstration HCBS (Apr-Jun increased FMAP)	0.52670	\$ 41,625	\$ 21,924	\$ 19,701	Total (Balance + Request)	\$ 1,060,819
Demonstration HCBS (Jul-Dec)	0.70645	\$ 83,375	\$ 58,900	\$ 24,475		
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -		
Supplemental (Apr-Jun increased FMAP)	0.05340	\$ -	\$ -	\$ -		
Supplemental (Jul-Dec)	0.41290	\$ -	\$ -	\$ -		
Administrative - Normal	0.50000	\$ -	\$ -	\$ -		
Administrative - 75%	0.75000	\$ -	\$ -	\$ -		
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 5,000	\$ 5,000	\$ -		
Administrative (Other) - 100%	1.00000	\$ 840,628	\$ 840,628	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 1,007,669	\$ 950,403	\$ 57,266		

CY 2012	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.71210	\$ 39,738	\$ 28,297	\$ 11,440	Remaining Award Funding	\$ 1,060,819
Demonstration HCBS	0.71210	\$ 137,500	\$ 97,914	\$ 39,586	Total Fed Costs	\$ 1,060,819
Supplemental	0.42420	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year	\$ 1,100,500
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 1,100,500
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 5,500	\$ 5,500	\$ -		
Administrative (Other) - 100%	1.00000	\$ 929,108	\$ 929,108	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 1,111,846	\$ 1,060,819	\$ 51,027		

APPENDIX K

CY 2013	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.71210	\$ 42,631	\$ 30,357	\$ 12,273	Remaining Award Funding	\$ 1,100,500
Demonstration HCBS	0.71210	\$ 150,000	\$ 106,815	\$ 43,185	Total Fed Costs	\$ 1,100,500
Supplemental	0.42420	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year	\$ 1,139,160
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 1,139,160
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 6,000	\$ 6,000	\$ -		
Administrative (Other) - 100%	1.00000	\$ 957,328	\$ 957,328	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 1,155,959	\$ 1,100,500	\$ 55,458		

CY 2014	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.71210	\$ 45,735	\$ 32,568	\$ 13,167	Remaining Award Funding	\$ 1,139,160
Demonstration HCBS	0.71210	\$ 162,500	\$ 115,716	\$ 46,784	Total Fed Costs	\$ 1,139,160
Supplemental	0.42420	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year	\$ 1,179,485
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 1,179,485
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 6,500	\$ 6,500	\$ -		
Administrative (Other) - 100%	1.00000	\$ 984,376	\$ 984,376	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 1,199,111	\$ 1,139,160	\$ 59,951		

APPENDIX K

CY 2015	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.71210	\$ 49,065	\$ 34,939	\$ 14,126	Remaining Award Funding	\$ 1,179,485
Demonstration HCBS	0.71210	\$ 175,000	\$ 124,618	\$ 50,383	Total Fed Costs	\$ 1,179,485
Supplemental	0.42420	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year	\$ 771,155
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ 771,155
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 7,000	\$ 7,000	\$ -		
Administrative (Other) - 100%	1.00000	\$ 1,012,929	\$ 1,012,929	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 1,243,994	\$ 1,179,485	\$ 64,508		

CY 2016	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.71210	\$ 52,637	\$ 37,483	\$ 15,154	Remaining Award Funding	\$ 771,155
Demonstration HCBS	0.71210	\$ 187,500	\$ 133,519	\$ 53,981	Total Fed Costs	\$ 771,155
Supplemental	0.42420	\$ -	\$ -	\$ -	Balance (Carry Over)	\$ -
Administrative - Normal	0.50000		\$ -	\$ -	Supplemental Award Request for next year	
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request)	\$ -
Administrative - 90%	0.90000	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1.00000	\$ 7,500	\$ 7,500	\$ -		
Administrative (Other) - 100%	1.00000	\$ 592,653	\$ 592,653	\$ -		
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -		
Total		\$ 840,290	\$ 771,155	\$ 69,135		