

Attachment A

Flexible Choices Rules

Choices for Care High/Highest Needs Manual

July, 2006

SECTION IV.12. Flexible Choices Pilot

Definition: Flexible Choices is a consumer or surrogate directed home and community based option which converts an individual's Home Based Service Plan into a cash allowance. Working with a consultant, the individual develops a budget which details expenditure of the allowance and guides the individual's acquisition of services to meet their needs. Flexible Choices option is being introduced as a pilot option limited to 50 participants. The purposes of the pilot are to determine the effectiveness of the option in meeting the needs of Choices for Care consumers, to fine-tune the most efficient and person-centered way to implement the option and to determine whether the option is fiscally prudent and cost-effective.

Eligibility: To be eligible for the pilot option for Flexible Choices, an individual must;

- 1) Be enrolled in Choices for Care (CFC) and directing their personal care services through a Consumer or Surrogate Directed option.
- 2) Complete the Self-Screening Tool (CFC 830) so as to indicate a capacity to handle the responsibilities of the option.
- 3) Meet criteria for Consumer or Surrogate Direction established by Choices for Care. (See Employer Agent Certification Form).

Participants in the Flexible Choices Pilot will be selected on a first-come/first-served basis determined by the date that the consulting agency receives the completed Flexible Choices referral form.

Initiation of Services: An individual begins receiving service through the Flexible Choices option through the following process:

- 1) The individual indicates his or her interest in Flexible Choices by completing a copy of the Flexible Choices Referral Form (CFC 831) and sending it to the Flexible Choices consultant (See "Role of the Consultant, below). The referral form includes consent for the consultant to talk to the case management agency, DAIL and the Fiscal ISO. Individuals may get a copy of this form either from their case manager, the regional Long Term Care Clinical Coordinator or the consultant.
- 2) The consultant makes contact with the individual within two working days of the receipt of the referral form.
- 3) The consultant will send out a copy of the Welcome Letter, Self-Screening Form and the *Welcome to Flexible Choices* brochure. In the event that the individual contacts the consultant initially, the consultant will include a referral form in their first mailing.
- 4) The consultant contacts the individual's current case manager and confirms that the individual is a consumer or surrogate directed participant in Choices for Care and requests a copy of the Independent Living Assessment (ILA), the personal care worksheet and the Service Plan including the Emergency Contacts and Back-up Plan.
- 5) The case manager sends this information within five working days of the request. The case management agency is also expected to share with the consultant individual information that will assist them in the completion of an appropriate budget for the individual.

- 6) The consultant contacts the individual to set up an initial care plan meeting with the individual within three working days of receipt of the material from the case management agency. This meeting takes place in the individual's home and at a time that is convenient for the individual. It may involve several support people for the individual.
- 7) At that meeting
 - a) The consultant and the individual review current ILA and determine whether it needs to be updated. The consultant will update or perform a new assessment as indicated by that review.
 - b) The consultant establishes an allowance amount (see "The Allowance" below) based either on the current or revised assessment.
 - c) The individual and consultant start the budget development process (see "The Budget" below).
 - d) The individual completes the Flexible Choices Informed Consent Form (CFC 832).
- 8) The consultant sends copy of the Informed Consent Form, any revised or new assessment information and the Allowance Approval Form (CFC836) to the regional Long Term Care Clinical Coordinator for utilization review and approval.
- 9) The Long Term Care Clinical Coordinator returns the approved allowance to the consultant and the participant.
- 10) The consultant and the individual sign an approved budget using the Budget Form (CFC 835).
- 11) The consultant forwards the completed budget with a start date to Fiscal ISO, the Flexible Choices project manager, the Long Term Care Clinical Coordinator and the individual with a start date for services.
- 12) The consultant, working with the participant, sends the Notice of Start of Services through Flexible Choices Option (CFC 833) and the Notice of Stop of Services through Flexible Choices Option (CFC 834) to the necessary service providers.

Consultant Services: The Flexible Choices consultant assists the individual in the development and management of their Flexible Choices budget. Consultant services are provided by Transition II. Consultants are responsible for:

- 1) Answering questions about the Flexible Choices and CFC program
- 2) Advising individuals in how to gain access to needed services
- 3) Conducting assessments and reassessments of the individual
- 4) Developing an allowance
- 5) Educating and supporting participants in their role as employers
- 6) Assisting the individual in developing their budget
- 7) Assuring that the participant has in place an emergency back-up plan.
- 8) Monitoring the services included in an individual's budget
- 9) Assessing the adequacy of care being provided
- 10) Certifying the ability of a consumer or surrogate employer to manage services
- 11) Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services
- 12) Reporting suspected cases of Medicaid Fraud to the State Medicaid Fraud Unit
- 13) Availability during regular working hours

Consultants are not responsible for:

- 1) Completing or processing payroll forms,
- 2) Payroll documentation and submission
- 3) Hiring, firing and training employees
- 4) Directly assisting individuals in accessing services outside Choices for Care (e.g., Food Stamps or Fuel Assistance)
- 5) Coordinating the delivery of services

Once services begin under a Flexible Choices budget, consultants are reimbursed by a monthly fee. There is no limit to how often an individual may access the services of their consultant.

The Allowance: The allowance is the number of dollars the individual has available to them from Flexible Choices 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:

- 1) *a base amount which will be the same for all participants:*

The base rate is the following costs, based on consumer/surrogate directed rates and pro-rated for two week increments:

- a) Case Management
- b) Respite/Companion Services
- c) Personal Emergency Response Services (at \$30/month)
- d) Equipment/home modifications
- e) ARIS ISO fees.

This rate will be \$453 per two weeks as January 28, 2007 but will change as the consumer/surrogate rates for these base services change across Choices for Care.

- 2) *a personal care amount:*

The personal care component is determined by multiplying the hours needed, as approved on the current Service Plan, by the consumer/surrogate personal care hourly rate, currently \$11.32 per hour, and pro-rated for 2 week periods.

- 3) *an adult day amount:*

For individuals receiving Adult Day services, this is calculated by taking the number of hours of Adult Day services in the currently approved Service Plan and multiplying it by the current Choices for Care Adult Day hourly rate (currently \$12). That sum is then added to the base and personal care amounts. Any allowance amount which arises from participation in Adult Day services, however, may be spent only on Adult Day services or for care at times the participant is scheduled for Adult Day services but is not able to attend. Should participants stop, start or modify their adult day participation, their allowance amounts will be adjusted accordingly by the consultant and approved as noted below.

Allowance amounts are approved by the Long-Term Care Clinical Coordinators, in consultation, if necessary, with the Flexible Choices Project Director.

The Budget: The budget details the plan by which the participant will spend their allowance to meet their needs, including emergency and back-up coverage. The consultant and the participant, along with whomever the participant asks for support, develop the budget after the allowance has been determined (Budget form – CFC 833).

The budget is broken into the following categories:

- 1) *Administrative fees:*
These are the monthly fees for the consultant and the Fiscal ISO. They are the same for all participants in the Flexible Choices option and are billed monthly at the beginning of the month.
- 2) *Personal care:*
The participant may determine how many hours of care they require and the rate at which they will pay their workers. Pay rates must not go below legal minimum wage standards and not out of line with prevailing regional wage standards for the work performed. The budgeted cost of personal care will include the costs of employer taxes.
- 3) *Adult Day services:*
These will match directly the dollar value of Adult Day services approved in the current Service Plan. This budget category may be used to pay for personal care hours provided at a time when the participant was scheduled to attend Adult Day services but could not due to either weather, illness or unscheduled closure of the Adult Day program.
- 4) *Other Services:*
These are activities provided by a professional in their professional capacity; e.g., nursing or occupational therapy. A “professional” is generally defined as someone licensed or certified by the state to perform a certain task.
- 5) *Goods:*
These are all other items and activities that do not fit into any other category. This includes tangible items, but also includes things such as health club memberships, yard and home maintenance and transportation.
- 6) *Cash:*
The participant may receive up to \$50 per two week period in cash. This is to purchase goods or services that are not amenable to billing or vouchers, such as cab rides or the neighbor who shovels the sidewalk.
- 7) *Savings:*
If a participant does not spend the entire allowance in a two week period, the unspent sum may be carried over to the future as savings. Participants may not carry over more than \$500 in savings from one state fiscal year (July 1 – June 30) to the next. There are two kinds of savings:
 - a) *Specified Savings:*
These are savings that are directed towards a specific purchase. There is no limit on how large these savings can get except as noted above.
 - b) *Rainy Day Savings:*

These are savings for expected costs that might arise. These savings cannot exceed 100% of the participant's monthly allocation.

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, wellbeing 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 (See "Monitoring").

Limits on the budget: How the participant spends his allowance is bounded by the following:

- 1) The items in the budget have to clearly relate to the participant's goals, identified needs and the maintenance of the participant's health, wellbeing and independence at home.
- 2) They cannot conflict with Medicaid regulations.
- 3) Certain items are *not* allowable:
 - a) Room and board for the participant: This includes rent/mortgage payments as well as payment for temporary lodging (e.g., hotels). It also includes normal food and toiletry purchases. Special foods or supplements that are indicated by the participant's needs may be allowable.
 - b) Gambling, alcohol and recreational drugs, both legal and illegal.
 - c) Items covered by other programs: This includes many items of durable medical equipment which are covered by other insurance, including Medicare and traditional Medicaid.
- 4) Certain items are generally not allowable except under special circumstances:
 - a) Recreational equipment: If the recreational equipment is clearly linked to maintaining independence, health or safety, then it will be considered. Goods whose primary purpose is clearly fitness over recreation (e.g., a stationary bicycle or special shoes for walking) are allowable.
 - b) Routine home costs: Utility bills and routine home maintenance, such as painting or roofing, typically fall under "room and board" and will not be allowed. In extraordinary situations where the participant's independence is at stake, a one-time expenditure may be allowed. Even in this case, however, all other possible resources need to have been exhausted first.
 - c) Clothing: Since clothing costs are generally included in a community maintenance allowance for Medicaid eligibility, participants are assumed to have adequate resources to cover these costs. Specialized clothing which relates to the documented needs of the participant, e.g., special shoes to encourage safe ambulation, are allowed.
- 5) Over the counter medications are allowable if they cannot obtain be covered by insurance and the participant has no patient share obligation.
- 6) Participants can spend only up to the amount of money they have available from their allowance.
- 7) If the participant chooses to purchase services which are regularly available Choices for Care services, i.e. personal care, companion or respite services from an agency, adult day services, case management or personal emergency system services, these

will be budgeted by the participant and billed by the agency to the participant at the agency's regular long-term care Medicaid rate.

- 8) The budget must include any funds that would be needed to cover pay for elements of the emergency back-up plan.

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.

Employer responsibilities: The role of the consumer/surrogate employer under Flexible Choices is outlined in the *Choices for Care /Flexible Choices Employer Handbook*.

The Fiscal Intermediary Services Organization: Under Flexible Choices, all Choices for Care expenses incurred by participants are billed through the Fiscal Intermediary Services Organization (ISO). Fiscal ISO services are provided by ARIS Solutions. All charges, except consultant and Fiscal ISO fees, require the participant's signature for payment. Fiscal ISO services are

Payroll: Participants' employees are paid according to procedures listed in the *Choices for Care/Flexible Choices Employer Handbook*. If a participant's payroll expenses are greater than the amount allotted for those costs, the participant grants The Fiscal ISO the authority to spend from other budget categories to allow them to cover payroll. The order in which these funds are drawn is as follows:

- 1) Savings
- 2) Cash
- 3) Goods
- 4) Services.

If there are not sufficient funds to cover the payroll, The Fiscal ISO will inform the participant and the consultant of the situation. If possible, those covered personnel costs will be covered in the next payroll, although the employer is ultimately responsible for covering his or her payroll. 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 care within the budgeted payroll amount.

Goods and Services: The procedure to purchase goods and services is as follows:

- 1) All goods or services must be documented in the participant's budget, either under goods or services or in savings. The participant is responsible for covering all purchases they make which are not in their budget.
- 2) Participants submit a Non-payroll Reimbursement Form to the consultant including documentation of the good or service to be purchased and total cost.
- 3) The consultant checks the Non-payroll Reimbursement Form against the participant's budget and, if the item is in the budget as requested, approves the request and forwards it to the Fiscal ISO.

- 4) The ISO cuts a check for the agreed upon amount written out to the vendor and forwards it to the participant (the participant can request the check go directly to the vendor) who completes the purchase.

Cash: To receive a cash payment:

- 1) The amount is documented in the participant's budget.
- 2) Participants request their cash allocation via a Non-payroll Reimbursement Form. After the first cash allocation, participants will document how they spent their cash since their last allocation and request a check for the amount they have spent.
- 3) Checks are sent at the end of the pay period after payroll checks have been processed. They appear to the participant as a check written out to them from the ISO.
- 4) Whenever possible, participants are expected to acquire receipts to document how they spent this allocation.

Participant Financial Statements: 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 and the Flexible Choices Project Manager.

Billing Medicaid: The Fiscal ISO is responsible for billing Vermont Medicaid for actual costs. Vermont Medicaid will reimburse requests for payment for any Long-term Care Medicaid service from only one provider (the Fiscal ISO) for dates of service billed using the Flexible Choices codes.

Budget Changes: Budget changes occur in two forms:

- 1) Budget changes that come about because the participant's needs have changed. This requires a new needs assessment to determine a new allowance amount and that process is detailed in "Determining the Allowance." A new budget would then be developed as laid out in the section "Budget Development."
- 2) Budget changes that come about not because of a change in participant needs. These changes reflect a change in participant priorities, or a new approach to meet existing goals. They do not require a new needs assessment but require a modification of all relevant sections of the Budget Form, including goals. These require only steps 8 – 11 listed in the "Initiation of Services" section.
- 3) The consultant will forward all budget changes to the Fiscal ISO, the LTCCC and the Flexible Choices Project Director.

Monitoring and Troubleshooting:

- 1) During the budgeting process, the consultant and the participant establish a monitoring process which lays out the schedule by which the consultant will contact the participant to see how the plan is functioning and how well the participant is doing.

- 2) The consultant also reviews the bi-weekly financial statement to assure that the participant's plan is being properly implemented.
- 3) 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
 - d) Discussion of any problems or concerns perceived by the consultant
- 4) Consultants will perform a home visit whenever the participant requests it. Consultants may initiate a home visit if they consider it called for. Home visits will occur at least annually to complete the annual reassessment.
- 5) Participants may contact the consultant whenever they need assistance. Participants are expected, however, to implement their emergency back-up plans should they need immediate assistance.

Leaving the Flexible Choices Option:

- 1) Participants in Flexible Choices may leave Flexible Choices and enter another option within Choices for Care upon request. The amount of services the participant receives in the new option will be determined by their assessed need at the time of the transfer from Flexible Choices. The consultant works with the participant and the receiving option to assure a smooth transition to the new option.
- 2) Whenever possible, consumer-employed staff will have reasonable notice that their services will no longer be required.
- 3) If the participant is moving to an ERC or Nursing Home, the consultant initiates a Change Report at the time of entry into the facility.
- 4) Involuntary disenrollment may occur because the participant (or surrogate as appropriate):
 - a) is no longer eligible for Choices for Care
 - b) is not able to manage the requirements of Flexible Choices
 - c) commits fraud or otherwise inappropriately uses their resources
 - d) dies
- 5) DAAIL staff makes the final determination in all cases of involuntary disenrollment.
- 6) Participants who are involuntarily disenrolled from Flexible Choices but are still eligible for Choices for Care shall have a plan for an expeditious and safe transfer to another Choices for Care option developed for them by their consultant working with the receiving option.